Commonwealth of Virginia

Community Mental Health Services
Block Grant Application
FY 2005-2007

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
August 2004

Table of Contents

Attachment D

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_FY 2005-2007 ___ FY 2005-2006 ___ FY 2005

STATE NAME: _Commonwealth of Virginia_____

DUNS #: _627383102_____

I. AGENCY TO RECEIVE GRANT

AGENCY: __Department of Mental Health, Mental Retardation and Substance Abuse Services

ORGANIZATIONAL UNIT: _Office of Mental Health Services, Planning and Evaluation

STREET ADDRESS: 1220 Bank Street_____

CITY: Richmond_____STATE: Virginia_____ ZIP:23218-1797_____

TELEPHONE: _____ FAX: _____

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: James S. Reinhard, M.D. _____TITLE: __Commissioner_____

AGENCY __Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

ORGANIZATIONAL UNIT: _Commissioner's Office_____

STREET ADDRESS: _Same as above_____

CITY: _____STATE:_____ ZIP: _____

TELEPHONE: __(804) 786-3921_____ FAX: _(804) 371-0092_____

III. STATE FISCAL YEAR

FROM: July 1_____ 2005_____ TO: June 30_____ 2006_____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Janet S. Lung, LCSW_____ TITLE: Director of Planning and Evaluation

AGENCY: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

ORGANIZATIONAL UNIT: Office of Mental Health Services, Planning and Evaluation

STREET ADDRESS: Same as above_____

CITY:_____STATE:_____ ZIP: _____

TELEPHONE: (804) 371-2137 FAX: (804) 786-1836

Executive Summary

FFY 2005 - 2007 CMHS Block Grant Application

Virginia is engaged in a process of transforming its mental health system to a recovery-oriented system. Supporting this process, the state has been fortunate to have the Community Mental Health Services Block Grant that has strengthened efforts to establish a comprehensive community-based mental health service system focused on the needs of consumers. Virginia is pleased to be part of the movement to achieve the promise of the President's New Freedom Commission and recognizes the importance of the CMHS Block Grant and performance partnership planning as part of Virginia's overall implementation strategy.

Virginia's public mental health, mental retardation and substance abuse services system is comprised of forty community services boards (CSBs) and sixteen state facilitites. The CSBs and state facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, mental retardation, or substance use disorders.

This is an exciting time of transition and transformation for Virginia's services system. The Department is currently implementing restructuring initiatives to develop and to enhance community-based care for individuals who would best be served in community settings. Our system has received, in the most recently approved budget, a down payment for investing in this work. Specifically, DMHMRSAS has received funding to support a significant number of new waiver slots and money for Olmstead initiatives such as private bed purchase money, Discharge Assistance Plans (DAP), and Programs of Assertive Community Treatment (PACT).

In addition, DMHMRSAS is proposing a new Vision that focuses on self-determination, empowerment and recovery. Virginia's system will not be restructured appropriately until we fully understand, fully embrace, and fully implement the concepts of self-determination, empowerment and recovery. The Department's Vision will be an essential component of an Integrated Strategic Plan, which will be developed in the fall of 2004 and will incorporate recommendations of the Regional Partnerships, the Special Populations Work Groups and the Mental Health Planning Council.

The table below shows the performance measures for the FFY 2005 Community Mental Health Services Performance Partnership Plan, their relevant criterion under P.L. 102-321, whether they are required by CMHS, and the uniform reporting system table where the data will be reported:

Performance Measure	Required by CMHS	Uniform Reporting System Table
Plan for Adult Services		
Criterion I: Comprehensive Community-Based Mental Health Service Systems		
State facility readmission rate	yes	Developmental Table 20A
Number of evidence-based practices provided by the state mental health authority (SMHA)	yes	Developmental Tables 16 and 17
Number of persons receiving evidence-based practices provided by the SMHA	yes	Developmental Tables 16 and 17
Positive consumer perceptions of outcomes	yes	Basic Table 11
State facility bed day utilization rate	Selected by state	
Criterion 2: Mental Health System Data Epidemiology		
Number of persons served by the SMHA (Increased access to services)	yes	Basic Tables 2A and 2B
Treated prevalence of serious mental illness	Encouraged by CMHS/ Selected by state	Developmental Table 14A
Criterion 3: N/A Only Applicable to Children's Services	**N/A**	**N/A**
Criterion 4: Targeted Services to Rural and Homeless Populations		
Level of shelter, housing and mental health services to homeless adults with serious mental illness	Selected by state	Developmental Table– To Be Developed
Criterion 5: Management Systems		
Percentage of SMHA-controlled expenditures used to support community programs	Selected by state	
Plan for Children's Services		
Criterion1: Comprehensive Community-Based Mental Health Systems		
State facility readmission rate for children	yes	Developmental Table 20A
Number of children receiving therapeutic foster care (evidence-based practice)	yes	Developmental Tables 16

State facility bed day utilization rate for children	Selected by state	
Criterion 2: Mental Health System Data Epidemiology		
Number of children served by the SMHA	yes	Basic Tables 2A and 2B
Treated prevalence of serious emotional disturbance	Encouraged by CMHS/ Selected by state	Developmental Table 14A
Criterion 3: Children's Services		
Positive perceptions of outcomes	yes	Basic Table 11
Cultural competency self-assessment	Selected by state	
Criterion 4: Targeted Servcies to Rural and Homeless Populations		
Number of children with serious emotional disturbance served by rural CSBs	Selected by state	
Criterion 5: Management Systems		
Percentage of SMHA-controlled expenditures used to support community programs for children	Selected by state	

The application describes goals, targets and action plans for each performance measure.

This application has been reviewed by the Virginia Mental Health Planning Council (MHPC), the 40 community services boards and many other interested stakeholders. The MHPC reviewed the first draft of the application at its meeting on July 14. Copies of the revised draft were distributed to the MHPC, all community services boards and other stakeholders on July 23. A public hearing was held on August 24 to solicit additional public comment. The MHPC membership requirements, membership list and composition, bylaws, charge/mission and comments are included with this application.

Part B.

Section I

1. **Funding Agreements**
2. **Certifications**
3. **Assurances**

Signed funding agreements, Certifications and Assurances are on the following pages.

COMMONWEALTH of VIRGINIA

Office of the Governor

Mark R. Warner
Governor

May 22, 2002

Ms. LouEllen M. Rice
Grants Management Officer
Office of Program Services
Division of Grants Management
Rockwall II Building, Suite 630
5515 Security Lane
Rockville, Maryland 20852

Dear Ms. Rice:

I am delegating responsibility for the administration of Virginia's Community Mental Health Services (CMHS) Block Grant and Substance Abuse Prevention and Treatment (SAPT) Block Grant to the Commissioner of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, effective this date. Questions concerning these grants should be directed to the Commissioner's office at:

The Virginia Department of Mental Health,
Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218
Telephone: (804) 786-3921

I would also like to authorize my Secretary of Health and Human Resources to make the required certifications and assurances associated with the CMHS and SAPT Block Grants on my behalf for this and subsequent years of my administration.

Sincerely,

Mark R. Warner

MRW/cmg

cc: The Honorable Jane H. Woods
Secretary of Health and Human Resources

✓James S. Reinhard, M.D., Commissioner
Department of Mental Health, Mental Retardation
and Substance Abuse Services

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2005

I hereby certify that Virginia agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[21] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2005, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

21. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Governor /Designee

Date 7/19/04

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Secretary of Health and Human Resources
APPLICANT ORGANIZATION	DATE SUBMITTED
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services	August 26, 2004

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____, if known: _____ Congressional District, *if known:* _____	Congressional District, *if known:* _____
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, *if applicable:* _____
8. Federal Action Number, if known:	9. Award Amount, if known: $
10.a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	b. Individuals Performing Services *(including address if different from No. 10a.) (last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Dana K Woods Print Name: Dana K. Woods Title: Secretary Health & Human Services Telephone No.: 804 786 7465 Date: 7-19-04

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

ATTACHMENT C

OMB Approval No. 0348-0040

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Secretary of Health and Human Resources
APPLICANT ORGANIZATION	DATE SUBMITTED
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services	August 26, 2004

4. Public Comments on State Plan

The following actions were taken to solicit comment on the state plan and block grant application.

- Copies of the draft state plan and were shared with the Mental Health Planning Council at its July 14th meeting for review, comment and discussion. A portion of the meeting agenda was devoted to review comment and discussion of the plan.
- The input of the Council was considered in the development of a subsequent draft of the application. This draft was mailed to each community services board, members of the Mental Health Planning Council and other interested persons requesting input and comments. CSBs were required to make the application available to the public in their community.
- A public hearing was held on August 24, 2004 to solicit and hear public comments on the draft FFY 2005 CMHS Block Grant Application. The following notice of the hearing was published on July 26th:

Department of Mental Health, Mental Retardation and Substance Abuse Services

August 24, 2004 - 10 a.m. – Public Hearing

Thomas Jefferson Building, 1220 Bank Street, 9th Floor Conference Room, Richmond Virginia. (Interpreter for the deaf provided upon request)

A public hearing to receive comments on the Virginia Community Mental Health Services Performance Partnership Block Grant Application for Federal Fiscal Year 2005. Copies of the application are available for review at the Office of Mental Health Services, 10th Floor, Thomas Jefferson Building and at each community services board office. Comments may be made at the hearing or in writing by no later than August 24, 2004 to the Office of the Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218. Any person wishing to make a presentation at the hearing should contact William T. Ferriss, LCSW. Copies of oral presentations should be filed at the time of the hearing.

Contact: Office of Mental Health, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218. Telephone (804) 786-4837, FAX (804) 371-0091, or (804) 371-8977/TDD

The notice appeared in five newspapers:

- The Washington Post
- The Richmond Times-Dispatch
- The Norfolk Virginian Pilot
- The Roanoke Times and World News
- The Danville Register and Bee

Section II. and Section III.
Set-Aside for Children's Mental Health Services Report and Maintenance of Effort Report

The table below shows the increases in expenditures for services for children with serious emotional disturbance from 1996 to 2004. These expenditures demonstrate compliance with the set-aside requirements of the CMHS Block Grant.

Section II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Expenditures for Children's Services	2,206,930	2,224,474	2,215,910	2,224,474	2,217,533	2,393,943	2,393,943	2,393,943	2,593,943
Target Funding Level	1,501,623	1,501,623	1,501,623	1,501,623	1,501,623	1,501,623	1,501,623	1,501,623	1,501,623

Source: Actual expenditures by state fiscal year.

Section III. MAINTENANCE OF EFFORT (MOE) REPORT

The table below shows the amount of state funds expended in each state fiscal year from 1996 to 2004. These expenditures comply with the maintenance of effort requirements of the CMHS Block Grant.

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Total State Funds for Mental Health Services	71,794,959	72,372,473	75,637,015	76,404,012	102,328,081	113,475,260	143,337,362	143,440,572	154,936,778

Section IV.

State Mental Health Planning Council Requirements

1. Membership Requirements and 3. Planning Council Charge, Role and Activities

Virginia's Mental Health Planning Council has bylaws that describe the council's mission, objectives, committee structure, membership requirements, governance and other important aspects of the council's functioning. The bylaws were developed by council members and approved by the full membership. The Council serves in an advisory capacity to the state and plays an important role in identifying areas for advocacy and system change and serving as an advocate for the development of a recovery-oriented system of care. In addition to its legislative charge to review, monitor and evaluate the adequacy of mental health services within the state, the council brings together a broad group of stakeholders that has been responsible for the development of many new programs and education for consumers and families. The bylaws of the Mental Health Planning Council of Virginia are included below:

Bylaws of the
Mental Health Planning Council of Virginia
(approved 1/25/00)

Article I
Name
The name of the organization is the Mental Health Planning Council of Virginia. (hereinafter referred to as the Council). The Council was established in 1988, pursuant to Public Law 99-660 (1986), now amended to PL 102-321.

Article II
Mission
The mission of the Virginia Mental Health Planning Council is to advocate for a consumer and family-oriented, integrated and community-based system of high quality mental health care.

Article III
Objectives of the Mental Health Planning Council

§1. The Council shall serve as the primary, on-going forum for articulating and building a consensus among consumers, families and other advocates, state agencies, and mental health providers and planners which will insure a system of treatment, services and supports of high quality for children and adults with serious emotional disturbances and serious mental illnesses.

§2. The Council shall review annually all expenditures and budgets in the state system for mental health services to satisfy the federal mandate that monies spent do not conflict with the restrictions of the Federal mandate. This review includes the Federal Block Grant Application, the Mental Health Plan(s) of Virginia to be expressed in the Performance Partnership Plan. Additionally, the Council shall review all other plans which are developed by the state which will impact mental health consumers including, but is not limited to, the state's six year Comprehensive Strategic Plan and the Community Services Performance Contract.

§3. The Council shall continuously monitor, evaluate and review the implementation of the State's Mental Health Plan including:

a. the allocation, adequacy and quality of services to children with serious emotional and mental disorders and adults with serious mental illness,

b. the congruence between existing services and the Commonwealth's stated values, priorities and goals, and,

c. the plan's impact on improving the quality of life for Virginia's mental health consumers and their families.

d. direct observation, visitation, and interviews by consumers, family members and advocates with regard to the programs, facilities, and human rights provisions of the state.

§4. The Council shall make recommendations to the various departments and agencies serving or funding services for consumers and their families, including, but not limited to the Commissioner and the Board of the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Governor of the Commonwealth of Virginia.

§5. The Council shall monitor the activities of and make recommendations to state Executive and Legislative Committees whose actions affect consumers and their families.

Article IV
Membership

§1. Membership shall be in accordance with federal laws and regulations.

§2. Each term of membership shall be for three years with no member serving more than two successive terms.

Article V
Governance

§1. Officers

a. The officers of the Council shall be the President, Vice Presidents for adult services and children's services, Secretary, and the immediate past president. A majority of the officers may not be state employees or providers of mental health services. Officers shall be elected for a one-year term. No officers may serve more than three successive terms in the same office.

b. The officers shall be elected annually by majority vote of the Planning Council members at a stated meeting.

c. In the absence of the President, a Vice President shall be the presiding officer.

d. The Secretary shall be responsible for seeing that a true record of the meetings and actions of the Council is compiled, for attesting to those records, and for such correspondence and other duties as the Council shall devise.

e. Officers may be removed by a majority of the Council for cause, subject to due process rights, including a bill of particulars, opportunity for mediation and the right to representation before the Council.

§2. Powers Reserved

a. The Council may review and approve the recommendations of the chair for appointments and special committees.

b. The Council may fill any vacancy among the officers, and designate a Vice President who shall become President if the President becomes unable to fulfill his or her duties.

c. The Council may establish and approve an annual budget for the operation of the Council.

d. The Council may develop an official position of the Council for dissemination with regard to any issue or matter affecting consumers or their families.

Article VI
Standing Committees

§1. Executive

This committee shall be responsible for coordinating the operations of the council. It shall comprise the President, the two Vice Presidents, Secretary, the immediate past president, and the chairpersons of all committees, standing and ad-hoc.

§2. Bylaws and Policy

This committee shall continually review the bylaws and policy manual to offer recommendations and modifications to the Executive Committee and the full council with regard to the structure and functioning of the organization.

§3. Membership and Training

This committee shall continually review the membership for compliance with federal law, evaluating full openness in participation in regard to race, creed or national origin, and geographical location, seek and recruit potential members, and report or make

recommendations to the Executive Committee and the full council on all issues regarding membership.

This committee shall also develop and manage the training and education of all council members, especially new council members. This committee may also review and promote training and education offered in the state as to content and quality of training for those serving mental health consumers and their families.

§4. Evaluation and Monitoring

This committee shall develop improved methods to continuously review all programs offered in the mental health system, to evaluate the effectiveness of data gathering, management, assessment and program review, for their effectiveness to consumers and their families, as well as to the program units. This committee shall report to the full council and cooperate with other committees.

§5. Adult Services

This committee shall review existing services, recommend modifications to existing services, collaborate in the development of additional or new service models, while promoting best practices, cooperating with other committees, and reporting to the full council.

§6. Child and Adolescent Services

This committee shall review existing services, recommend modifications to existing services, collaborate in the development of additional or new service models, while promoting best practices, cooperating with other committees and reporting to the full council.

§7. Advocacy and System Reform

This committee shall advocate for the rights and needs of those with mental health concerns while continually obtaining input from the consumers, their families, and advocacy organizations. The committee shall make recommendations to the full council based on their findings.

§8. Budget and Funding

This committee shall

a. continually review and advise the council on expenditures and budgeting for mental health services through the DMHMRSAS and all other programs within the state. It shall alert the council with regard to matters of concern and make recommendations to improve the funding of mental health services. The Committee shall identify other financial resources. This committee shall report to the full council and other committees regularly.

b. develop a spending plan for Council activities and monitor expenditures to assure successful implementation.

Article VII
Meetings

§1. Frequency. The Council shall meet at its pleasure, according to a set schedule, and at least quarterly.

§2. **Notice.** Notice of at least two weeks shall be provided for special meetings, and the business to be attended shall be included with notice.

§3. **Quorum.** A quorum shall be fifty percent of the total membership and a majority of the consumer, family member, and advocate members.

§4. Conduct of the meeting. Ordinarily, business shall be conducted as a committee of the whole, but the chair or any two members may require that substantive matters be considered under *Robert's Rules of Order, Newly Revised*.

§5. **Conflict of Interest.** Members shall abstain from voting upon such matters in which they have a financial interest.

§6. **Open Meetings**. The meetings of the Council shall be open, unless the work of the Council would be of a confidential nature at law which would preclude an open session.

Article VIII
Amendments

§1. Amendments shall be proposed at least one month in advance.

§2. Amendments shall be circulated to all members at least two weeks in advance by mail, supplemented by email or fax.

§3. Amendments must be approved by a 3/5 vote of those present and eligible to vote.

Proposed by the *ad hoc* bylaws committee, chair – Mary Ann Beall, met 12/4/1999, revised by the MHPC on 12/14/99 for final approval, approved on January 25, 2000 with amendments @ Art. VII, § 3 and @ Art. VI, § 7, reflecting an agreement on 12/14/99.

2. State Mental Health Planning Council Membership List and Composition

The membership list and composition of the Virginia Mental Health Planning Council is on the following pages.

List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone & FAX
Van Avery	Family Member of SMI adult	MH Assoc. of Danville/Pittsylvania County	1225 West Main Street P.O. Box 11066 Danville, VA 24543 Phone: (434)792-3700 Fax: (434)791-3187
Raymond Bridge	Consumer		2809 Rosemary Lane Falls Church, VA 22042-1811 Phone: (202)720-5447 Fax: (703)534-6730
Alicia Bush	Provider	Prince William CSB	15941 Donald Curtis Drive Woodbridge, VA 22191 Phone: (703)792-7095
H. Lynn Chenault	Provider	New River Valley CSB	700 University City Boulevard Blacksburg, VA 24060-2706 Phone: (540)961-8421 Fax: (540)557-4042
Paul J. Cook	Other (not state employee or provider)		4346 Mulcaster Terrace Dumfries, VA 22026 Phone: (703)558-7809
Ann Cutshall	Consumer	Virginia Association for the Deaf Blind	2313 Wright Avenue Richmond, VA 23225 Phone: (804)231-4256
Lynn DelaMer	Other (not state employee or provider)	MH Assoc. in Fredericksburg	2217 Princess Anne Street Suite 219-1 Fredericksburg, VA 22401 Phone: (540)371-2704 Fax: (540)372-3709
Linda Edwards LCSW, LSATP	Provider	Central Virginia CSB	Courtland Center, 620 Court Street Phone: (434)455-2063 Fax: (434)455-2720
Vicky M. Fisher	Consumer	Mental Health Association of Virginia	8260 Ellerson Green Court Mechanicsville, VA 23116 Phone: (804)225-5591 Fax: (804)225-5593

Name	Type of Membership	Agency or Organization Represented	Address, Phone & FAX
Everett Franklin	Family Member of SMI adult		3406 Kim Court Apartment #B5 Roanoke, VA 24018 Phone: (540)774-1018
Catherine Hancock	State Employee	Department of Medical Assistance Services	600 East Broad Street, Suite 1300 Richmond, VA 23219 Phone: (804)225-4272 Fax: (804)786-1680
Robin L. Hulbert Ph.D.	State Employee	Department of Corrections	6900 Atmore Drive, #2091 Richmond, VA 23225 Phone: (804)674-3299
Mary Kaye Johnston	State Employee	Department of Rehabilitative Services	8004 Franklin Farms Drive P.O. Box K300 Richmond, VA 23288 Phone: (804)662-9968 Fax: (804)662-9140
Joyce B. Kube	Family Member of SED Child	Parents and Children Coping Together (PACCT)	P.O. Box 26691 Richmond, VA 23261-6691 Phone: (804)559-6833 Fax: (804)559-6835
Valerie Marsh	Family Member of SED Child	NAMI-VA	P.O. Box 1903 Richmond, VA 23218 Phone: (804)225-8264 Fax: (804)643-3632
James M. Martinez Jr.	State Employee	Department of Mental of Health, Mental Retardation, and Substance Abuse Services	P.O. Box 1797 Richmond, VA 23214 Phone: (804)786-4837 Fax: (804)371-0091
Mary McQuown	Consumer		2401 Payne Road Chesapeake, VA 23323 Phone: (757)487-6633
Lisa T. Moon Ph.D.	Other (not state employee or provider)		4309 Soundview Lane Chesterfield, VA 23832 Phone: (804)674-4164 Fax: (804)674-4169

Name	Type of Membership	Agency or Organization Represented	Address, Phone && FAX
Margaret Nimmo-Crowe	Other (not state employee or provider)	Voices for Virginia's Children	701 East Franklin Street, Suite 807 Richmond, VA 23219 Phone: (804)649-0184 x24
Carolann Pacer-Ramsey	Family Member of SED Child	Families 1st of Virginia, Inc.	1711 East Main Street Suite 100 Richmond, VA 23223 Phone: (804)649-8804 Fax: (804)644-4642
Brian Parrish	Consumer	VOCAL	PO Box 1248 Charlottesville, VA 22902 Phone: (434)243-7878
Cynthia Power	Consumer	VOCAL	107 Elkhorn Road Charlottesville, VA 22903 Phone: (434)923-4543
Sherry Rose	Consumer		10320 Luria Commons Court #36 Burke, VA 22015 Phone: (703)250-3498
Joe Speidel	State Employee	Department of Housing and Community Development	Jackson Center 501 North Second Street Richmond, VA 23219 Phone: (804)371-7175 Fax: (804)371-7091
Dana Traynham	State Employee	Virginia Office for Protection and Advocacy	202 North Ninth Street, 9th Floor Richmond, VA 23219 Phone: (804)225-3226 Fax: (804)225-3221
Tony Vadella	Provider	Poplar Springs Hospital	P.O. Box 3060 350 Poplar Springs Drive Petersburg, VA 23805 Phone: (804)748-7490
Dennis Waite Ph.D.	State Employee	VA Department of Juvenile Justice	Behavioral Services Unit 1601 Bon Air Road Richmond, VA 23235 Phone: (804)786-0798

Name	Type of Membership	Agency or Organization Represented	Address, Phone && FAX
Irene Walker-Bolton	State Employee	Department of Education	P.O. Box 6Q Richmond, VA 23216 Phone: (804)225-2709
Nancy W. Ward	Family Member of SED Child	DMHMRSAS Board	107 Rich Neck Road Williamsburg, VA 23185 Phone: (800)363-3687 Fax: (757)253-1807
Jack Wood MBA	Provider	Catawba Hospital	5525 Catawba Hospital Drive Catawba, VA 24070 Phone: (540)375-4201 Fax: (540)375-4394
L. William Yolton	Family Member of SMI adult		3825 Gibbs Street Alexandria, VA 22309 Phone: (703)360-3657 Fax: (703)360-1992

Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	31	
Consumer	5	16%
Family Member of SED Child	5	16%
Family Member of SMI adult	4	13%
Other (not state employee or provider)	4	13%
TOTAL C/S/X, Family Members & Others	18	58%
State Employee	7	23%
Provider	6	19%
TOTAL State Employees & Providers	13	42%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning , operation, funding, and use of mental health services and related support services.

4. State Mental Health Planning Council Comments and Recommendations

Letter from Ray Bridge based on Planning Council comments and discussion at July 14 meeting

Placeholder for letter from MHPC, including its comments and recommendations.

MHPC letter continued

Part C. State Plan

Section I. Description of State Service System

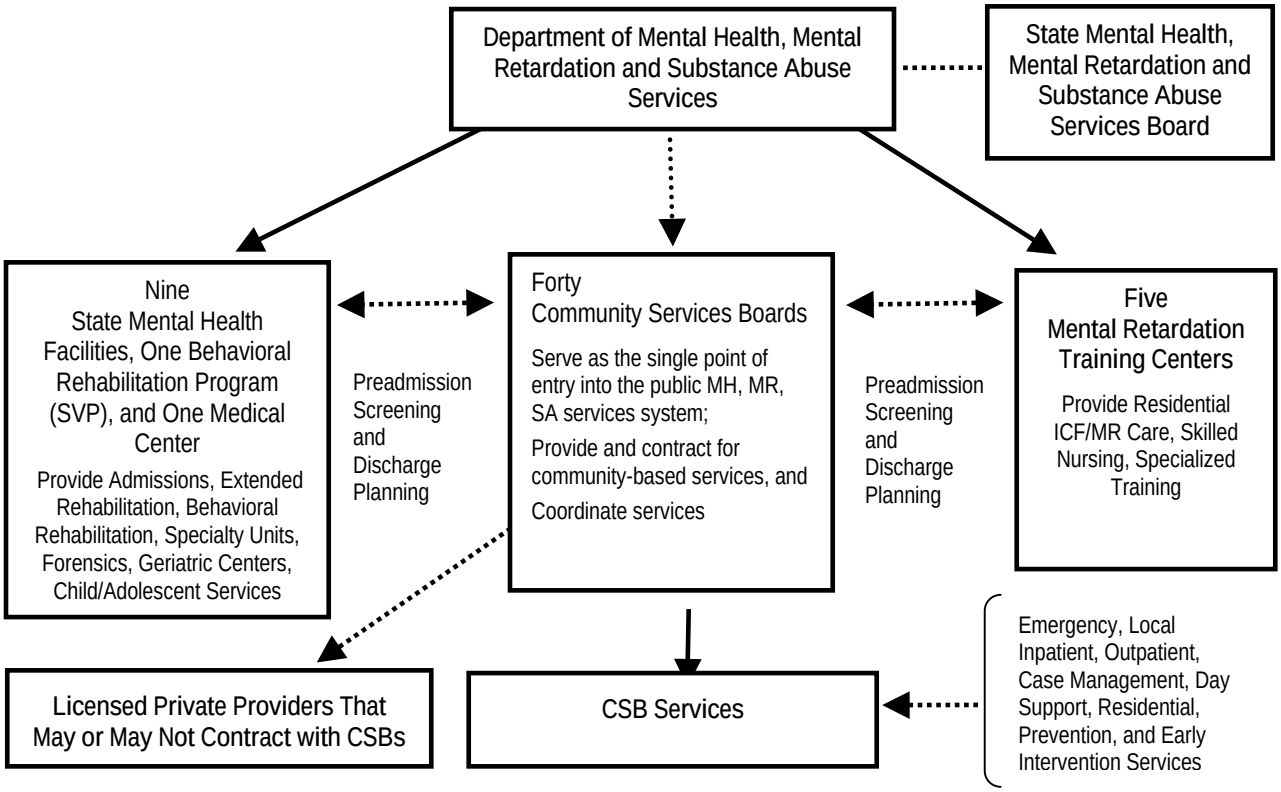
This information is primarily excerpted from Virginia's Comprehensive State Plan 2004-2010. The Code of Virginia at 37.1-48.1 requires the Department of Mental Health, Mental Retardation and Substance Abuse Services to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation and substance abuse services. The same code section requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor. The Comprehensive State Plan provides an excellent and thorough background against which to understand the state's mental health plan in the context of the broader system.

A. Overview of Virginia's Mental Health System

Services System Overview and Structure

Virginia's public services system includes the Department, the State Mental Health, Mental Retardation, and Substance Abuse Services Board (the State Board), 16 state mental health and mental retardation facilities, and 40 community services boards (CSBs) that may provide services directly or through contracts with private providers.

The following diagram outlines the current relationships between these system components. Solid lines depict a direct operational relationship between the involved entities (e.g., the Department operates the state facilities). Broken lines depict non-operational relationships (e.g., policy direction, contracting, or coordination).



Statutory Authority, Mission, and Responsibilities of the Department and State Board

Title 37.1 of the *Code of Virginia* establishes the Department as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. By statute, the State Board offers policy direction for Virginia's services system.

The mission of the Department's Central Office is to provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcoholism and other drug addiction). It seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Responsibilities of the Department include:

- Providing leadership that promotes strategic partnerships among and between CSBs, state facilities, other services system partners, and the Central Office;
- Providing direct care, treatment, and habilitation services in state mental health and mental retardation facilities (civil and forensic services);
- Supporting the provision of accessible and effective community mental health, mental retardation, and substance abuse treatment and prevention services through a network of CSBs;
- Assuring that public and private mental health, mental retardation, and substance abuse services providers adhere to licensing standards; and
- Protecting the human rights of individuals receiving of mental health, mental retardation, and substance abuse services.

Characteristics of CSB Mental Health Services

Eligibility for mental health services provided by CSBs is determined by clinical criteria for each local program. Emergency services are available to anyone in the geographic area served by the CSB, while other services are generally targeted to residents of the CSB service area. In FY 2002, 107,351 individuals received CSB mental health services. This represents an unduplicated count of all individuals receiving any mental health services. Numbers of individuals receiving mental health services by core service follows.

Number of Individuals Receiving CSB Services by MH Core Service in FY 2002

Core Service	# Served	Core Service	# Served
Emergency Services	43,966	Alternative Day Support Arrangements	200
Local Inpatient	1,256		
TOTAL Local Inpatient Services	1,256	**TOTAL Day Support Services**	8,109
Outpatient Services	70,471	Highly Intensive Residential	344
Intensive In-Home	1,914	Intensive Residential	201

Core Service	# Served	Core Service	# Served
Case Management	38,599	Supervised Residential	1,193
Assertive Community Treatment	231	Supportive Residential	2,866
TOTAL Outpatient & Case Management	111,175	Family Support	143
Day Treatment/Partial Hospitalization	491	**TOTAL Residential Services**	4,747
Therapeutic Day Treatment - C&A	951	Early Intervention Services	438
Rehabilitation Services	5,601	Purchase of Individualized Services*	1,135
Sheltered Employment Services	67	Special Projects**	5,909
Supported/Transitional Employment	754	**TOTAL Individuals Served**	176,735
Supported Employment - Group Models	45	**TOTAL Unduplicated Individuals**	107,351

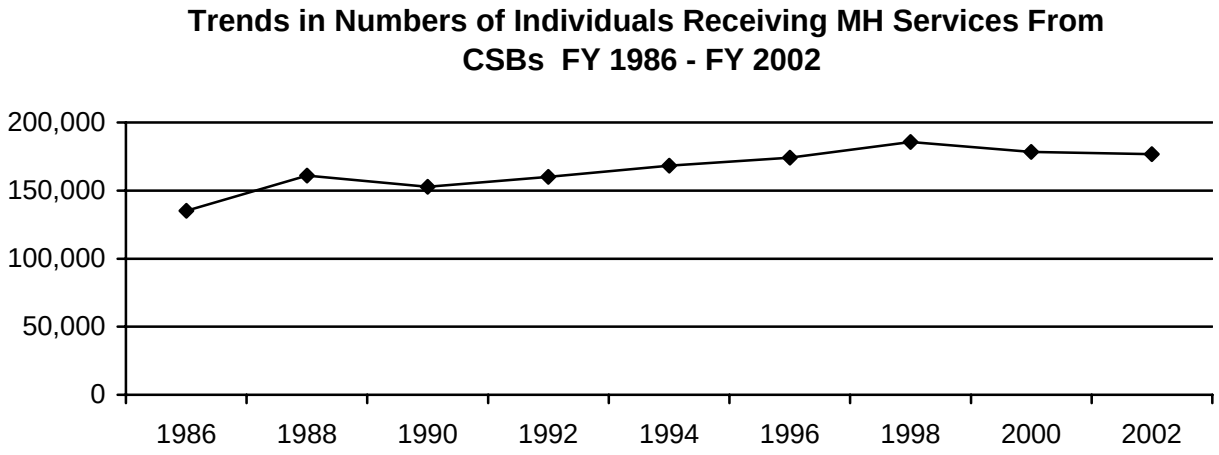
Source**:** FY 2002 CSB 4th Quarter Performance Reports

Notes: TOTAL Individuals served are not unduplicated numbers because some individuals receive more than one type of service and sometimes receive services in more than one program area.

*Purchase of Individualized Services (POIS) includes 415 individuals served in the Discharge Assistance Project (DAP) and 720 children and adolescents served in non-CSA Mandated mental health services.

**Special Projects include 1,256 individuals served in Programs of Assertive Community Treatment (PACT), 1,219 individuals served through Assisted Living Facilities (ALF) Projects, and 3,434 individuals served in Community Residential Services.

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2002, the numbers of people receiving various CSB mental health services grew from 135,182 to 176,735, an increase of 31 percent. Trends in the numbers of individuals receiving mental health services from CSBs are displayed on the following graph.



These numbers are duplicated counts of individuals receiving services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories.

Characteristics of State Mental Health Facilities

State mental health facilities provide highly structured intensive inpatient treatment services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic patients. The Joint Commission for Accreditation of Healthcare Organizations (JACHO) has accredited all state mental health facilities. The Commonwealth licenses child and adolescent services provided by the Southwestern Virginia Mental Health Institute and the Commonwealth Center for Children and Adolescents (CCCA) under the CORE regulations for residential children's services.

Operating (staffed) bed capacities for each state mental health facility follow.

Mental Health Facility Operating Capacities – June 12, 2003

MH Facility	# Beds	MH Facility	# Beds	MH Facility	# Beds
Catawba Hospital	110	Eastern State Hospital	529	Southern VA MHI	72
Central State Hospital	320	Northern VA. MHI	127	Southwestern VA MHI	176
CCCA	48	Piedmont Geriatric	135	Western State Hospital	281
TOTAL OPERATING CAPACITY (BEDS)					1,798

Note: The Hiram W. Davis Medical Center, with an operating capacity of 74 beds, is not included in this table or the next, since it is primarily a medical and skilled nursing facility.

A new behavioral rehabilitation facility opened in October 2003. This facility provides individualized treatment services in a secure facility to individuals who are civilly committed as sexually violent predators.

In FY 2003, there were 5,946 admissions to and 6,008 separations from the nine state mental health facilities, excluding the Hiram Davis Medical Center. The average daily census by facility follows:

Mental Health Facility Average Daily Census (ADC) – FY 2003

MH Facility	ADC	MH Facility	ADC	MH Facility	ADC
Catawba Hospital	93	Eastern State Hospital	486	Southern VA MHI	76
Central State Hospital	280	Northern VA. MHI	120	Southwestern VA MHI	147
CCCA	35	Piedmont Geriatric	122	Western State Hospital	252
TOTAL STATE MH FACILITY AVERAGE DAILY CENSUS					1,609

Source: PRAIS, ESH provided data for June and July 2003.

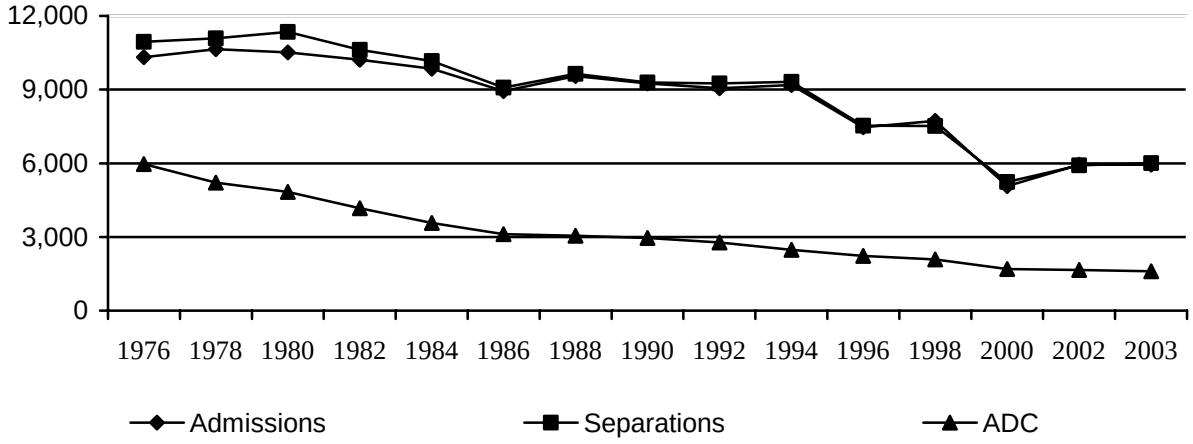
Between FY 1976 – FY 1996, the average daily census at state mental health facilities declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 – FY 2003, the average daily census declined by 28 percent (from 2,222 to 1,609).

Between FY 1996 – FY 2003, admissions declined by 26 percent (from 7,468 to 5,946). After a significant decline in the number of admissions between FY 1998 – FY 2000 (2,362), the number of admissions increased by 154 between FY 2000-FY 2001, by 713 between FY 2001 - FY 2002 and by 10 between FY 2002 - FY 2003.

Between FY 1996 – FY 2003, separations declined by 20 percent (from 7,529 to 6,008). Separations include normal discharges, discharges against medical advice, transfers, and deaths of registered patients. After a substantial decline between FY 1998 – FY 2001 (2,346), the number of separations increased by 738 between FY 2001 - FY 2002 and by 93 between FY 2002 - FY 2003.

Admission, separation, and average daily census trends (FY 1976 - FY 2003) for state mental health facilities, excluding the Hiram Davis Medical Center, follow.

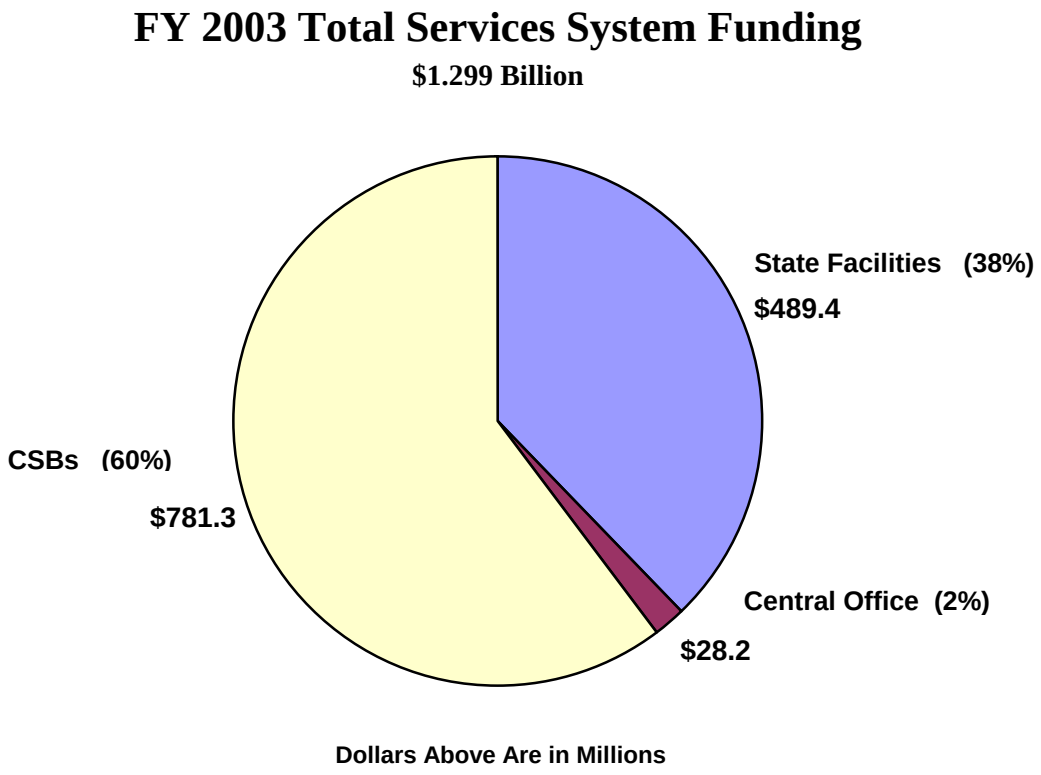
MH Facility Admissions, Separations, and Average Daily Census (ADC) Trends: FY 1986 - FY 2003.

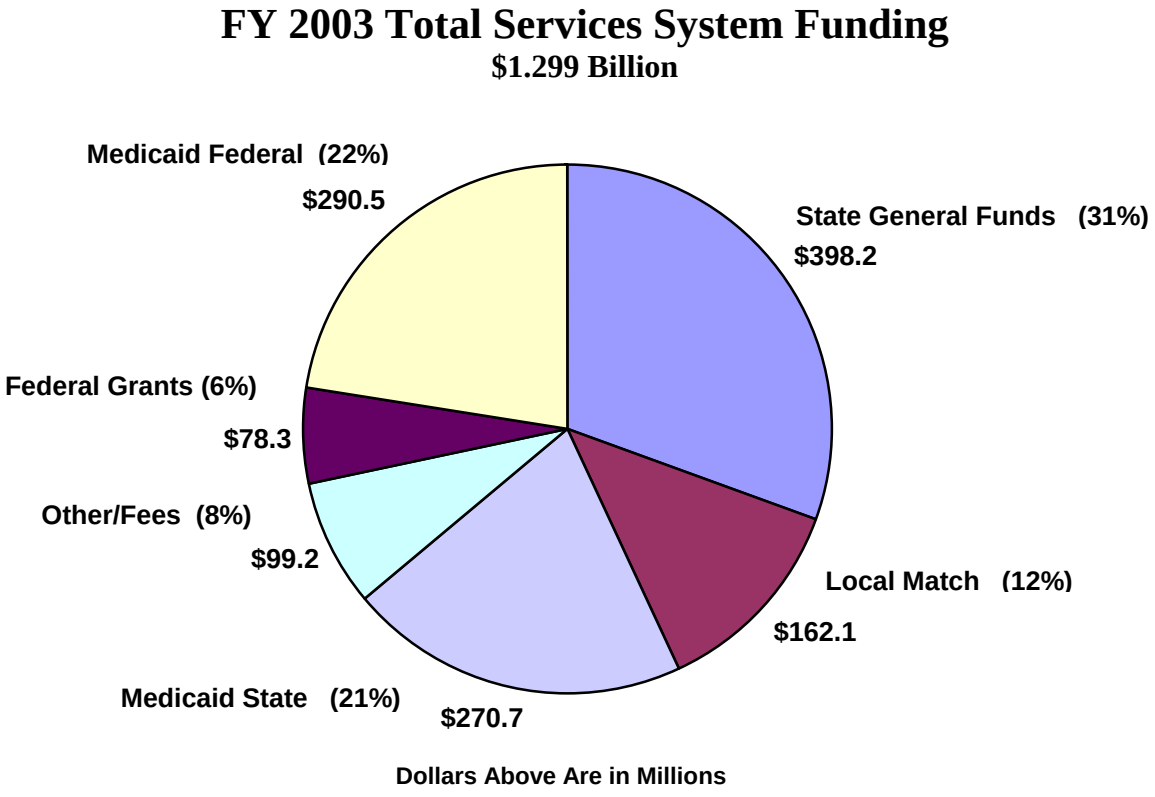


Note: Includes the Virginia Treatment Center for Children through FY 1991, when it transferred to MCV.

Services System Funding

Charts depicting the services system's total resources for FY 2003 from all sources (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid Mental Retardation Home and Community-Based Waiver (MR Waiver) payments to private vendors, follow.

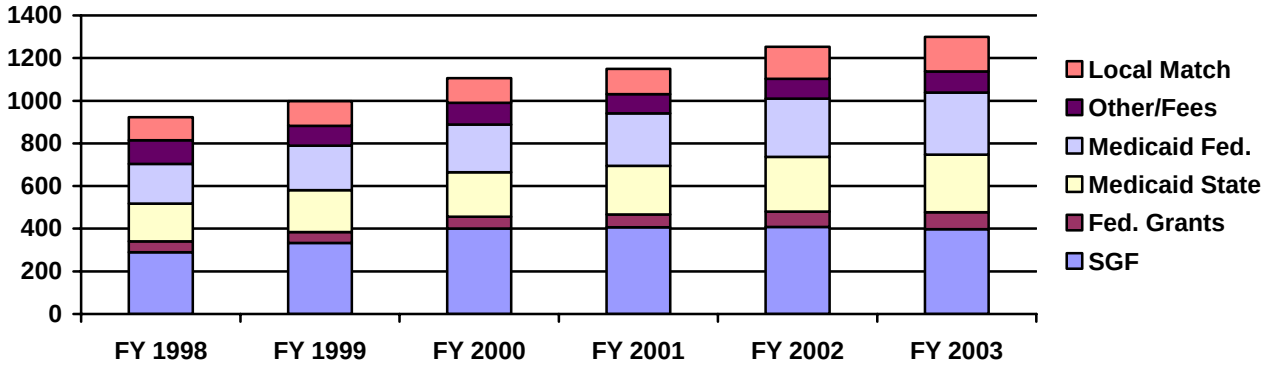




Funding Trends

Between FY 1998 and FY 2003, total services system funding grew by 40 percent from $923.2 million to $1.299 billion. The following table depicts funding by source (in millions) for this time period.

	FY 1998	FY 1999	FY 2000	FY2001	FY 2002	FY 2003
State General Funds	290.3	332.8	399.9	406.5	408.2	398.2
Federal Grants	51.0	51.3	56.2	59.8	72.2	78.3
Medicaid - State	176.0	196.3	209.0	228.4	256.9	270.7
Medicaid - Federal	186.7	209.1	223.2	245.5	273.3	290.5
Other/Fees	111.3	93.2	102.0	90.6	92.8	99.2
Local Match	107.9	115.9	115.9	118.9	149.3	162.1
Total	$923.2	$998.6	$1,106.3	$1,149.7	$1,252.7	$1,299.0



B. Summary of Areas Needing Attention

Current and Future Service Needs

CSB Waiting Lists

The following table displays the number of Virginians who were on CSB waiting lists for community mental health services on April 11, 2003.

Numbers of Individuals on CSB Waiting Lists for Mental Health Services on April 11, 2003

Population	Number Receiving Some CSB Services	Number NOT Receiving Any CSB Services	Total on CSB Waiting List
Adults with Serious Mental Illnesses	4,327	703	5,030
Children & Adolescents With or At Risk of Serious Emotional Disturbance	994	320	1,314
Total MH	5,321	1,023	6,344

To be included on the CSB waiting list for CSB services, an individual had to have sought the service and been assessed by the CSB as needing that service on April 11, 2003. CSB staff also reviewed their active cases to identify individuals on their active caseloads who were not receiving the amounts or types of services that they needed. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons who needed services over the course of a year.

State Mental Health Facility Discharge Lists

There are currently 109 patients in state mental health facilities whose discharges have been delayed due to extraordinary barriers.

Students Receiving Special Education Services

According to the Virginia Department of Education, based on counts made on December 1, 2001, there were 14,182 students with a primary disability (as defined by special education law) of emotional disturbance and 13,425 students with mental retardation receiving special education services. Included in this count were students in a local school division, in either of the two schools for the deaf and the blind, in a state mental health or mental retardation facility, and in a private day or residential placement made by the school division or Comprehensive Services Act team. These numbers do not include children who are not receiving special education services. Also not included are students in private placements made by the parents or children educated by the Department of Correctional Education. As these students age out of special education services, many will require community-based treatment or habilitation services to maintain the skills they learned in special education.

C. New Developments and Issues

Improving Access to Community-Based Services in a Restructured System of Care

Olmstead Task Force Report Recommendations

In 1999, the United States Supreme Court issued a decision in the case of Olmstead v. L.C., 119 S. Ct. 2176 (1999). This case involved a challenge under Title II of the Americans With Disabilities Act (ADA), 42 U.S.C. § 12132, by two women with mental disabilities who lived in mental health facilities operated by the state of Georgia, but who wished to live in the community. In the decision, the Court held that a State is required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when:

The State's treatment professionals determine that such placement is appropriate;

The affected persons do not oppose such placement; and

The placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities.

Although the Olmstead case involved two individuals with a mental disability, the decision is broad in its scope and applies to all qualified persons with disabilities covered by the ADA. It applies to all qualified individuals with mental, physical, or sensory disabilities. It applies to individuals who are institutionalized or who are at risk of institutionalization.

The Olmstead decision does not prohibit institutional placement, but, in fact, recognizes it as the least restrictive setting for some individuals who cannot handle or benefit from community settings. Additionally, the decision affirms that there is no federal requirement that imposes community-based treatment of patients who do not desire it.
States must make reasonable accommodations in programs in order to provide community-based services to qualified individuals, unless doing so would fundamentally alter the services provided. This "fundamental alteration" standard is met if the state can demonstrate that it has:

A comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and

A waiting list that moves at a reasonable pace not controlled by the state's efforts to keep its institutions fully populated.

In evaluating a State's fundamental alteration defense, the courts must consider, in view of the resources available to the State: the cost of providing community-based care; the State's responsibility for maintaining a range of facilities for the care of persons with diverse disabilities; and the State's obligation to mete out services equitably. A simple comparison of the cost of providing care for individuals in the community with the cost of institutional care is not sufficient.

In Item 329 M of the 2002 Appropriation Act, the General Assembly directed the Department to convene a task force to "develop a plan for serving persons with disabilities that implements the recommendations of the Olmstead decision (Olmstead v. L.C., 119 S. Ct. 2176 [1999])." Virginia's Olmstead Task Force was chaired by Secretary Woods and had 70 members representing individuals with disabilities, family members, advocates, providers, local government, members of the General Assembly, and other interested individuals and groups. Fifteen state agencies that provide or oversee services to individuals with disabilities served as members of, and provided resources to support, the Task Force. The Task Force worked from July 2002 to August 2003. Its Final Report was submitted to the Governor, the Joint Commission of Health Care, and the Chairmen of the House Appropriations and Senate Finance Committees on September 15, 2003.

The Task Force examined major issues that cut across populations of individuals with disabilities. Topic areas included:

Accountability	Educating the Public, Consumers & Families
Employment	Housing
Prevention &Transition Services	Qualified Providers
Transportation	Waivers.

The Olmstead Task Force Final Report includes a vision, goals statement, and over 200 recommendations organized by implementation time frame and responsible entity. Key components of the vision are: individual choice; consumer-directed services and supports; accountability to individuals, family members, decision-makers, and the public; sufficient numbers of qualified providers; safe, available, accessible, and affordable housing and transportation; an opportunity to work; and a full continuum of care, from self care through institutional care. The Task Force goal statement states that qualified individuals with disabilities in Virginia must, if they choose, be afforded the opportunity to:

Move to a more integrated setting appropriate to their needs;

Stay in the community of their choice once they have moved into a setting that is appropriate for their needs;

Live successfully in the community of their choice while receiving appropriate services in order to prevent unwanted institutionalization; and

Work collaboratively with all public and private partners to ensure the implementation of the Olmstead decision.

Recommendations include actions that would have a *direct impact on individuals with disabilities* and actions that provide *systems support*. Each recommendation also contains implementation actions, responsible entities, and a general time frame during which each proposed action would be initiated.

The Olmstead Task Force Report and information about the Olmstead decision and the Task Force is available on the Task Force's website--"One Community"-- at www.olmsteadva.com.

In response to the Olmstead Task Force Report recommendations, the Governor is working with the Secretary of Health and Human Resources to:

Establish a collaborative, multi-agency team to cost out recommendations in the Report;

Direct state agencies to implement administrative actions that do not require legislation or funding;

Direct agencies to prepare legislative and budget proposals for his consideration; and

Establish an Olmstead Oversight Advisory Committee, comprised of individuals with disabilities, family members, advocates, and providers, to monitor implementation of the recommendations, receive annual progress reports from the multi-agency team and advise the Governor on suggested policy and administrative changes.

Community Capacity Development in Response to Documented Demand

Virginians with serious mental illnesses or emotional disturbances, mental retardation, or substance use disorders should receive high-quality treatment and services that:

Are appropriate to the individual's service and support needs;
Reflect the individual's choice and that of his family;
Promote recovery, rehabilitation, and self-determination to the greatest extent possible;
Provide positive outcomes; and
Demonstrate cost-effectiveness.

Services should be provided in the most integrated setting appropriate to the needs of the individual. Services should build on, rather than replace, the individual's natural supports (family, friends, neighbors, churches, and other community organizations). This includes doing everything possible to keep the individual's family structure in place for as long as this is possible.

Anyone in crisis due to a mental disability or substance use disorder needs an array of intensive intervention services in the community that provide emergency, short-term local hospitalization, detoxification, and crisis stabilization services, in essence, a services safety net. Such services:

Address an immediate crisis that could escalate to a point where the person becomes a danger to himself or others,

Prevent a further deterioration in functioning level or life circumstances that could cause the person to need longer-term services,

Improve an individual's ability to function effectively in personal, work, or school environments, and

Provide early intervention necessary to prevent, for some individuals, the onset of a life-long mental disability.

Individuals who have the most serious illnesses or severe disabilities also need individualized longer-term services that provide continuing care over longer periods designed to enable individuals to achieve their full potential in all aspects of their daily lives. In a community-based

system of care, this includes a full-range of community outpatient and case management, day treatment and rehabilitation, and residential services as well as services provided in state mental health facilities. In addition to services and supports provided or arranged by professionals, non-traditional services and supports such as those provided by individual-operated peer-support programs and services provided in partnership with neighborhood and community organizations also important.

Through concerted efforts by individual and family advocates and services providers, Virginia has worked diligently to establish a comprehensive array of community-based services and to reduce waiting lists for services. However, because of the Commonwealth's budget crisis, this progress has largely stalled. In FY 2002, 192,149 Virginians received mental health, mental retardation, and substance abuse services provided by CSBs, compared to 201,607 individuals served in FY 2000. Department funding to CSBs for community services was reduced by over $12.5 million in FY 2003 and FY 2004 because of the budget crisis.

Although CSBs worked to reduce the impact of these and other state or local funding reductions on individuals receiving services, they could not avoid cuts in direct services. Some programs were eliminated or consolidated. Others experienced staff or service hour reductions. Consequently, CSBs could not provide the level or range of services required by individuals on their caseloads and others who had sought services but were unable to obtain them.

CSB Waiting Lists

The Department asked the CSBs to complete a point-in-time automated database to document the specific service requirements of individuals on CSB waiting lists on April 11, 2003. To be included in the database, an individual had to have sought a service from the CSB and been assessed by the CSB as needing that service. A summary of services needed, individual risk factors or special circumstances, and average service wait times by program area follow.

CSB Mental Health Waiting List Information

Numbers of Individuals on CSB MH Service Waiting Lists by Service
April 11, 2003

Service	Adult	C&A	Service	Adult	C&A
Outpatient Services					
Psychiatric Services	1,760	457	Intensive SA Outpatient	319	43
Medication Management	1,700	411	Intensive In-Home	0	307
Counseling and Psychotherapy	1,836	704	Case Management	1,602	498
Assertive Community Treatment	399	0			
Day Support Services					
Day Treatment/Partial Hospitalization	351	0	Supported Employment Group Model	215	10
Rehabilitation	691	9	Transitional or Supported Employment	458	36

Service	Adult	C&A	Service	Adult	C&A
Therapeutic Day Treatment	0	386	Alternative Day Support Arrangements	310	53
Sheltered Employment	264	8			
Residential Services					
Highly Intensive (MH)	277	46	Supervised	457	17
Highly Intensive (SA Detox)	84	5	Supportive	810	29
Intensive	152	34	Family Support	287	133
Early/Infant-Toddler Intervention					
Infant and Toddler Intervention	0	3			

Of the children and adolescents on waiting lists for CSB mental health services, 1,158 were identified by the CSBs as currently needing specific services, 53 were identified as needing specific services beginning the 2006-2008 biennium, and 103 were identified as needing specific services beginning in the 2008-2010 biennium.

Of the 5,030 adults and 1,344 children and adolescents on CSB MH waiting lists, a number were identified by CSBs as having other disabilities, special circumstances or service needs, or specific risk factors. These follow.

Numbers of Individuals on CSB MH Waiting Lists With Other Disabilities, Special Circumstances or Risk Factors: April 11, 2003

Circumstance/Risk Factor	Adult	C&A	Circumstance/Risk Factor	Adult	C&A
In Jail, Correctional Facility, Juvenile Detention Facility, or Criminal Justice Involvement	213	109	Unable to Communicate with Verbal Speech	41	10
MI/SA and SA/MI Diagnoses	984	50	Traumatic Brain Injury	100	11
MI/MR and MR/MI Diagnoses	174	41	Dementia	88	0
MI/MR/SA Diagnoses	27	2	High or Extensive Physical or Personal Care Needs	404	43
Developmental Disability Other Than MR	129	74	Major Medical Condition/ Chronic Health Problem	1,329	52
Deafness or Hearing Loss	76	7	Limited English Proficiency (National Origin)	254	28
Blindness or Visual Impairment	82	6	Receiving Special Education	0	514
Non-ambulatory or Major Difficulty in Ambulation	144	5	Care Giver Illness or Disability	165	0

Circumstance/Risk Factor	Adult	C&A	Circumstance/Risk Factor	Adult	C&A
At Risk of Being Homeless or Out or Home Placement	948	144	Social Services/Juvenile Justice System Involvement	0	285
Current Residence Is Not Satisfactory or Appropriate to Individual's Needs	635	79	Current Residence Is Satisfactory But Supports Provided are Inadequate	766	386
Currently Unemployed or No Day Support Options	2,076	0	Aging Out of CSA or Foster Care Financing for Residential Services	0	27
Social Supports Are Limited or Lacking	2,627	582	Caregiver Is Unable or Unwilling to Provide Support	0	180
No Guardian or Legally Authorized Representative	269	2	Family Has Petitioned to be Relieved of Custody	0	7
Aging Care Giver	307	82	Currently Truant, Expelled, Suspended, or School Drop Out	0	117

Social supports were lacking for 52 percent of the adults and 44 percent of the children and adolescents on CSB waiting lists.

Of the adults on waiting lists, 41 percent were unemployed or lacked day support options.

For children and adolescents 39 percent were aging out of special education services, 8 percent were in a juvenile detention facility, and 22 percent had social services/juvenile justice system involvement. Almost 9 percent were currently truant, expelled, or suspended or had dropped out of school.

Nineteen percent of adults were at risk of being homeless. Fifteen percent of adults and 29 percent of children and adolescents resided in a satisfactory setting but lacked adequate supports. The current residence was not satisfactory or appropriate to the needs of 13 percent of adults and 6 percent of children and adolescents. The individual's caregiver was unable or unwilling to provide support for 14 percent of the children and adolescents, with a small number of families having petitioned to be relieved of custody.

Almost 20 percent of adults on waiting lists had a co-occurring substance abuse diagnosis and 26 percent had a major medical condition or chronic health problem.

CSBs also estimated the number of weeks individuals waited prior to their actual receipt of specific services. Average wait times across the 40 CSBs for specific mental health services follow. The longest service wait times were reported for residential services, with an average wait of just over one year for supervised residential services.

Average MH Service Wait Times in Weeks Across CSBs by Service and Population

Service	Adult	C&A	Service	Adult	C&A
Initial Assessment					
Initial Assessment	3.67	3.04			
Outpatient Services					
Medication Management	7.94	4.21	Psychiatric Services	8.61	4.55
Assertive Community Treatment	17.73	N/A	Intensive In-Home	N/A	4.65
Counseling and Psychotherapy	7.20	5.13	Case Management	6.76	3.19
Day Support					
Day Treatment/Partial Hospitalization	5.13	N/A	Supported Employment Group Model	7.11	3.50
Rehabilitation	11.38	2.50	Transitional or Supported Employment	13.42	4.00
Therapeutic Day Treatment	N/A	6.00	Alternative Day Support Arrangements	20.57	1.00
Sheltered Employment	10.17	12.00			
Residential Services					
Highly Intensive	16.25	5.00	Supportive	34.19	16.00
Intensive	22.14	9.25	Family Support	10.00	5.60
Supervised	52.83	12.50			

State Facility Discharge Waiting Lists

One area of emphasis in the Olmstead Task Force Report is the elimination of state facility discharge waiting lists. In September 2003, there were 109 patients in state mental health facilities on discharge waiting lists for longer than 30 days because of a variety of extraordinary discharge barriers. Since the Department implemented the Discharge Protocols on January 2, 2001, 348 individuals have been placed on state mental health facility discharge waiting lists. Of these, 239 have been discharged (a discharge rate of 69 percent), with an average waiting period of 144 days. The following table provides information about these 348 individuals, including the number of individuals with specific major discharge barriers, the number discharged, the discharge rate, and the average days waiting prior to discharge.

State Mental Health Facility Discharge Rate by Barrier to Discharge Type
January 2001 Through September 2003

# Patients	Discharge Barrier	# Discharged	Discharge Rate	Average Wait
71 (20%)	Nursing Home	46	65%	203 days
54 (16%)	Behaviors/Provider	44	81%	136 days
64 (18%)	Waiting List – ALF	51	80%	114 days
27 (7%)	Specialized Placement – Funding	20	77%	214 days
26 (7%)	Benefits	16	69%	118 days
26 (7%)	Refuses Discharge Plan	18	69%	139 days
22 (7%)	LAR/Nursing Home	13	59%	240 days
19 (6%)	NGRI	7	37%	178 days
12 (2%)	MR Waiver Placement	7	58%	176 days
8 (2%)	Medical Needs/ Supports	7	88%	84 days
5 (1%)	Out of State Transfer Delayed	2	50%	156 days
2 (1%)	Other Supports	2	100%	170 days
2 (1%)	Out of Catchment Placement	1	50%	91 days
2 (1%)	Legal - Placement	0	0%	--
2 (1%)	Insurance/Benefits	0	0%	--
2 (0%)	Living Accommodations	1	50%	113 days
1 (0%)	INS/Deportation	1	100%	116 days
1 (0%)	Veterans Administration	0	0%	--
348	Total	239	69%	144 days

For the 173 individuals in state training centers who, with their legally authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a training center, the primary mechanism for successful community placements is the Medicaid Home and Community-Based Waiver (MR Waiver) program. Although the number of MR Waiver slots was increased by the 2003 General Assembly, these slots were limited to individuals who are currently in the community. The lack of available MR Waiver slots presents a significant discharge barrier for these individuals.

Implementation of Evidence-Based Practices

Background

Evidence-based practices (EBPs) are those interventions that integrate the best research evidence with the best clinical expertise and patient values. (Sackett, 2000, or Institute of Medicine Report Crossing the Quality Chasm, 2001). Evidence-based practices emphasizing individual participation, choice, recovery, and other individual-centered outcomes have the potential to

significantly improve the quality of care for individuals receiving services.

The 1999 Surgeon General's Report on Mental Health prompted increased attention among policy-makers and payers to the issues associated with implementation of evidence-based practices in mental health. The Surgeon General's Report underscored that, for the most part, the effective interventions that exist for many mental disorders are simply not available to the majority persons who could benefit from them.

There are several evidence-based practices for the treatment of serious mental illnesses in adults and serious emotional disturbance in youth. These include:

*For adults with serious mental illness**:***

- Integrated dual disorders treatment
- "New generation" medications
- Medication management
- Assertive community treatment (ACT)
- Illness management and recovery
- Family psychoeducation
- Supported employment

For children and adolescents:

- Multi-systemic therapy
- Family involvement
- Therapeutic foster care
- School programs
- Integrated community treatment
- Some prevention interventions

In the area of substance abuse services, rapid advances in brain-imaging technology, pharmacology and evaluation of counseling techniques and supports have radically altered approaches to treating substance use disorders in the last five years. Scientific evidence overwhelmingly supports addiction and dependence as diseases of the brain. Concurrently, pharmacological approaches to treating substance use disorders have expanded from methadone and LAAM to include buprenorphine and naltrexone for the treatment of opiate addiction and alcoholism, respectively. Currently, the National Institute on Drug Abuse is operating two clinical trial demonstrations in Virginia, both at CSBs. The use of specific counseling techniques, particularly Motivational Interviewing, has been widely studied and shown to be effective in helping persons with substance use disorders address characteristic denial and weak commitment to treatment. Finally, a greater understanding of the prevalence and impact of co-occurring disorders on the development and treatment of substance use disorders is demanding more attention to treatment models for those individuals suffering from both mental illness and substance dependence.

Experts in the field of prevention have developed rigorous approaches to evaluate and identify prevention programs that are effective. These programs are recognized by state and federal mental health, substance abuse, education and juvenile justice systems as evidence- or science-based programs.

Virginia's Experience With EBPs

Virginia has made significant progress in implementing selected evidence-based practices. For example, Programs of Assertive Community Treatment (PACT) have been developed in 12 CSB areas, and Multi-Systemic Therapy for adolescents is offered at several other CSBs. Most individuals have access to the "new generation" medications, whether in CSB or state facility programs. Outcome data from the PACT initiatives have shown dramatic reductions in state hospital usage, increased stability in living situations for individuals, and reduced involvement

with criminal justice agencies. The Department also supports family psycho-education through its contracts with family support groups and the Southwest Virginia Behavioral Health Board. Most individuals receiving services in the public mental health system, however, do not have consistent access to such services.

The Department also funds 12 science-based prevention programs for families, including services for new parents, for Head Start children and their parents, and families with children and adolescents. Program directors are working closely with program developers and university faculty to evaluate the programs. Thus far, program evaluation data indicate that children gained in their awareness of drug harm and increased their levels of cooperation and social skills. Evaluation results for parents show fewer inappropriate parental expectations and increased overall parenting and monitoring skills. Evaluation of the families showed an increase in communication skills and family interaction.

Strengthening Evidence-Based Practices for the Future

The Department, CSBs, individuals receiving services and families, and others have recognized the importance of working together to develop, disseminate, and support evidence-based service models and uniform clinical practices that will promote positive individual outcomes. Such efforts would include defining the extent and quality of "evidence" necessary for services and interventions to qualify as evidence-based practices (e.g., multiple randomized clinical trials, quasi-experimental research, qualitative evidence, etc). Adoption of uniform clinical practices by the CSBs would also help promote consistency across services throughout the state and permit clear identification of service system gaps where they exist. While still allowing for local variation and innovation, a core set of evidence-based clinical practices for community services across the state also would help ensure informed individual choices and ease of movement from one service area to another. The Department must increase its focus on adopting evidence-based practices for persons with mental illness, mental retardation and substance use disorders to effectively achieve its mission.

Today, advances in communication technology greatly enhance the dissemination and transfer of information to practitioners and can make the most current research and other information readily accessible to most practitioners, allowing them to integrate this information into their daily practice. Opportunities exist to strengthen Virginia's mental health, mental retardation, and substance abuse services system through this technology.

To effectively adopt evidence-based practices, several ingredients must be in place, including

Commitment of leadership at each level (state, local, program),

Education and skill building for practitioners,

Supportive administrative practices,

Incentives and rewards,

Feedback mechanisms (e.g., measurement of outcomes), and

Stable long-term financial support for EBPs.

Additional resources will be needed to raise awareness of evidence-based practices, enhance competency among providers, and to develop and sustain programs and services.

Access Issues of Individuals with Multiple or Co-Occurring Disabilities

Individuals Who Have Co-Occurring Mental Retardation and Mental Illness

The National Association for the Dually Diagnosed (NADD) has broadly defined dual diagnosis as "*the co-existence of the manifestations of both mental retardation and mental illness."* The Report of the Northern Virginia MI/MR Workgroup states that persons with a dual diagnosis can be found at all levels of mental retardation (mild, moderate, severe, profound) and that the full range of psychopathology that exists in the general population also can co-exist in persons who have mental retardation. Estimates of the frequency of dual diagnosis vary widely in the published clinical literature; however, many professionals have adopted the estimate that 20-35 percent of all persons with mental retardation have a psychiatric disorder. The dual diagnosis population has two major sub-groups with very different treatment needs.

Individuals who typically have a serious mental illness and who function at the mild or moderate level of retardation (MI/MR) – This group most often resides in the community and enters the service system because of challenging, difficult-to-manage behaviors that may pose a threat of serious harm to themselves or others. Some may be at increased risk for admission to a state mental health facility because they require specialized supports in a secure environment.

Individuals who have severe or profound mental retardation and a serious mental illness (MR/MI) – This group is more likely to be receiving care in an institutional setting, whether in the community or in a state training center.

Both groups require service providers who are knowledgeable and skilled in diagnosis and treatment or habilitation of both mental illness and mental retardation.

Families and individuals receiving services often are not aware that they can have diagnoses of mental retardation and mental illness, and they sometimes fail to recognize the signs and symptoms of mental illness. This lack of awareness increases the likelihood that they will cycle between the mental health and mental retardation service systems and face multiple barriers to accessing the services and supports they need.

Providing appropriate treatment for this population has been recognized as problematic in all states. Virginia does not have a systematic approach for meeting the needs of this population. The current service delivery system is organized by program area (MH, MR, or SA), with staff training and expertise typically limited to one program area. There also is a lack of community-based expertise in diagnosing, treating, and supporting individuals who require specialized assistance. Nevertheless, there are pockets of excellence in every state, including Virginia, which could be replicated.

In July 2002, the Department established a Dual Diagnosis Steering Committee, which is comprised of representatives from CSBs, state psychiatric facilities, state training centers, family members, and private providers. This group is examining the treatment needs of this population and exploring potential strategies for more effectively using current resources and building capacity within the system. Regional teams that mirror the Steering Committee are identifying current service gaps and disseminating knowledge about "best practices" and model programs already in existence. Teams also are identifying alternative funding sources (e.g., start-up or demonstration grants) and developing effective incentive plans for system change.

The Northern Virginia MI/MR Workgroup recently completed a review of cases known by community and state mental health and mental retardation facility professions to have a dual diagnosis. Based on these case reviews, clinical profiles were developed. These profiles were used to identify current services and needed service enhancements that are critical to achieving successful outcomes. These include:

Formal agreements for collaboration and jointly shared responsibility between mental retardation and mental health services from both the Department and CSBs;

Collaboration among Department and CSB mental retardation and mental health agencies and private providers of residential and day or vocational services;

Flexible funding, with immediate availability of funds based on levels of support needed rather than on diagnosis;

Specialized supervision and well-trained staff that receives specialized training for all personnel at the clinical, medical, managerial and direct services levels in MR/MI issues;

Accurate psychiatric assessment and diagnoses;

Interdisciplinary assessment involving staff of both mental retardation and mental health agencies;

Psychiatrists with previous knowledge of and training in MR/MI issues;

Intensive case management, with smaller case loads allowing the case manager to take a much more active role in helping the individual develop and maintain everyday life skills and build natural circles of support;

Sufficient staff resources in both residential and day or vocational locations to allow for one-to-one staffing during crisis and stabilization periods;

Development of strategies to address crisis situations that are an integral part of an overall treatment or discharge plan;

Availability of significant behavioral consultation hours and more hands-on care than the typical behavioral consultation;

Partial hospitalization and crisis stabilization to avoid removing individuals from their homes and as an option to inpatient hospitalization and institution-based care with minimum bureaucracy for the relatively few individuals who need this level of care;

Specialized outpatient services;

Program for Assertive Community Treatment (PACT) model specialized in MR/MI issues, and mobile crisis intervention teams of clinical and direct care professionals with expertise in MR/MI issues;

Suitable day placements to meet individual needs, including vocational and non-vocational options, as well as community college life skills degree programs;

Community residential placement options and in-home supports with a full range of alternatives (e.g., group homes, specialized foster care, 2-3 bed homes, supervised apartments, mentor roommates, and Life Coaches) and financial incentives for residential private providers to keep beds available when individuals are placed out of the home for short durations during crises;

Prioritized review of requests and applications for MR Waiver funding for individuals with MR/MI issues;

Frequent coordination and follow-up by CSB case management staff with residential and vocational placements to ensure adherence to treatment plans and to prevent slippage and crisis episodes; and

Family and individual education and support groups to recognize dual diagnosis, learn more about treatments, and offer support for dealing with the challenges of a dual diagnosis.

The Northern Virginia MI/MR Workgroup concluded that: "Services should be based upon individual consumer needs and supports rather than disabilities, thus avoiding 'problem shifting' that occurs between MR and MH agencies. Much can be accomplished through collaboration with existing community resources rather than creating new resources in response to present limitations of single MR or MH service sectors."

Individuals Who Have a Co-Occurring Substance Use Disorder and Mental Illness

Co-occurring disorders are an illness characterized by the simultaneous presence of two independent medical disorders – psychiatric disorders and alcohol and other drug use disorders. Co-occurring disorders can occur at any age. Research suggests that as many as half of the adults who have a diagnosable mental disorder will also have a substance use disorder during their lifetime. (Kessler et al. 1994, Regier et al. 1990) Seven to ten million people in the United States have at least one mental disorder in addition to a substance-related disorder. (SAMHSA 2002, Watkins et al. 2001) In 1998, SAMHSA estimated that 7.2 million persons between the ages of 18-54 with co-occurring disorders are living in households. This equates to approximately 191,210 adults in Virginia.

The impact of co-occurring disorders is significant for individuals, families, service providers, and society. Co-occurring disorders are increasingly associated with negative outcomes. (RachBeisel, Scott and Dixon, 1999) Substance use adversely affects the course and outcome of mental disorders for individuals with serious mental illness. Research shows that these individuals are susceptible to poor functioning and clinical outcomes including:

More severe illness symptoms;

Increased hospitalization;

Decreased social functioning and non-compliance with treatment regimes;

An elevated risk of contracting HIV and hepatitis diseases;

Greater difficulty gaining access to health services; and

Increased risk for violent behavior.

A number of studies have shown that co-occurring disorders are associated with increased costs of health services, mainly due to an increase in the use of acute psychiatric services, longer average length of stay in hospitals, and higher hospital admission rates. (AACP, 2000, Leon 1998, Dickey et al. 1996, Bartels et al. 1993, Drake et al. 1991, Lyons and McGovern 1989) Hoff and Rosenheck (1998) investigated the cost of treating substance abuse among patients with and without co-occurring disorders and found that individuals who were dually diagnosed had increased service utilization and cost regardless of which diagnosis was designated as the primary disorder. The public system faces difficult questions in setting appropriate goals and using resources wisely since substance abuse tends to increase expensive service utilization. (RachBeisel, and Dixon, 1999)

In the recent SAMHSA report (2002) to Congress on Co-occurring Disorders, practices resulting in the most positive outcomes for persons with co-occurring disorders included:

Integrated treatment models;

Use of integrated assessments;

Programs of assertive community treatment (PACT);

Modified therapeutic communities; and

Motivational interviewing/enhancement to promote engagement in the therapeutic process and enhance positive behavioral change.

Literature supports the notion that an integrated approach to treatment is regarded as most favorable. (RachBeisel, Scott, and Dixon 1999; Drake et al., 2001, Schneider 2000, Drake and Wallach 2000) Integrated treatment, as opposed to sequential or parallel forms of treatment, offers the most positive outcomes for individuals experiencing co-occurring disorders.

The following successful models incorporate evidence-based treatment practices for individuals with co-occurring disorders have been developed and implemented.

Motivational interviewing, either alone or coupled with other techniques such as Cognitive Behavior Therapy and Family Intervention, is effective for treating persons with co-occurring disorders of schizophrenia and substance use. (Graeber et al. 2003, Barrowclough et al. 2001)

The New York Model of treatment is based on symptom multiplicity and severity, rather than on specific diagnoses. In this model, the appropriate service level (consultation, collaboration, integrated services) is matched to the corresponding severity level to improve outcomes. (SAMSHA 2002, NASMHPD and NASADAD, 1998)

The Comprehensive, Continuous, Integrated System of Care (CCISC) is designed to be an accepting umbrella for all best practices in the treatment of individuals with co-occurring disorders. It incorporates the principles of integrated system planning; uniform program capability in dual diagnosis; universal practice guidelines; dual competence; concurrent treatment for simultaneous primary disorders; ease of access; treatment matching to subtypes of dually diagnosed individuals; utilization of parallel phases for treatment planning; readiness stages are not a barrier; treatment over time; and maintaining continuity of relationships with clinicians. (Minkoff, 1989, 1991, 2000, 2001)

Individuals with co-occurring disorders challenge the treatment system. Program barriers for serving persons with co-occurring disorders include a lack of clear service models, administrative guidelines, contractual incentives, and quality assurance procedures and outcome measures needed to implement dual diagnosis services.

The Department's role in addressing this challenge is to ensure that there is a collaborative and integrated response to the needs of individuals with co-occurring disorders. Three major systemic barriers restrict services to persons with co-occurring disorders – restricted services funding, the lack of specifically designed programming, and lack of trained professionals.

Recent budget cuts have forced large state systems to review the effectiveness of programs funded by state and federal funds, measure cost-effectiveness, and ask for increased accountability. The Department's Office of Substance Abuse Services (OSAS) and Office of Mental Health (OMHS) advocate the use of "best practices" and evidence-based practices as part

of larger systems change initiatives. This includes the collaborative work of the National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors, which uses the New York model of consultation, collaboration and integrated services while recognizing the compatibility of this model with the CCISC model. (Minkoff, 1989, 1991, 2000, 2001)

The Department recently submitted an application for a federal grant, State Incentive Grant for the Treatment of Persons with Co-occurring Substance Related and Mental Disorders. The 3-year grant would involve collaboration between Central Office and numerous CSBs; validate instruments for the screening of co-occurring disorders at a pilot site; build capacity of the existing infrastructure by documenting the current workforce; and provide training on evidence-based and culturally competent practices and co-occurring disorders delivered by nationally recognized experts.

Individuals Who Are Deaf, Hard of Hearing, Late Deafened, or Deafblind

The Department's Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or DeafBlind (Advisory Council), composed of service providers and state agency representatives, is charged with assessing critical needs for this population, providing service oversight, and recommending future direction for service improvements and development in all three disability areas. The Advisory Council has noted that hearing loss affects 8.6 percent of the general population. Between five and ten percent of these individuals also experience a loss of vision. Research generally suggests that the prevalence rates for serious mental illness within the deaf, hard of hearing, late deafened, and deafblind populations are consistent with those found in the general population. Some studies suggest a higher prevalence rate for adjustment and personality disorder, emotional or behavior dysfunction, and substance abuse. Contributing factors to this may include isolation due to communication barriers, lack of family support, underemployment, late onset of hearing loss and lack of social identification.

Communication barriers associated with hearing loss also prevent access to CSB programs, resulting in the need for specialized and accommodated services for this population. The Department is committed to improving the capacity of the service system to address the communication and cultural access needs of this special population to ensure availability and access to needed specialized resources, professionals, support services, and technical assistance on a regional basis. The Advisory Council has identified the following issues for action during the next three biennia:

State facilities and CSBs could benefit from additional technical assistance resources to address the communication and cultural needs of this population;

Regional programs need additional resources to meet the service needs of this population

Inter-regional collaboration is needed to ensure the continuity of care and the effective provision of mental health, mental retardation and substance abuse services.

D. Legislative Initiatives/Changes, If Any – N/A

E. Regional/sub-State programs, community mental health centers, and resources of counties and cities for provision of mental health services

Community mental health, mental retardation, and substance abuse services are provided in Virginia through a network of 40 CSBs. CSBs function as:

The single point of entry into publicly-funded mental health, mental retardation, and substance abuse services, including preadmission screening to access needed state facility services, case management and coordination of services, and pre-discharge planning for individuals leaving state facilities;

Service providers, directly and through contracts with other providers;

Advocates for individuals receiving CSB services and persons in need of services;

Community educators, organizers, and planners;

Advisors to the local governments that established them; and

The primary locus of programmatic and financial accountability.

CSBs exhibit tremendous variety in almost all aspects of their composition, organizational structures, and array of services. Section 37.1-194.1 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with local government departments (LGDs). In several localities, Behavioral Health Authorities (BHAs), established pursuant to Chapter 15 in Title 37.1 of the *Code of Virginia*, may deliver community mental health, mental retardation, and substance abuse services instead of a CSB. In this Plan, the term CSB includes BHA.

Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served		Total CSBs
		One	Two or More	
Administrative Policy CSBs[1]	7	7	3	10
LGD with Policy-Advisory CSB	1	1	0	1
Operating CSB[2]	0	2	26	28
Behavioral Health Authority[2]	0	1	0	1
TOTAL CSBs	8	11	29	40

[1] Seven of these CSBs are city or county departments; even though 3 CSBs are not, all use local government employees to staff the CSB and deliver services.

[2] Staff in these 28 CSBs and one BHA are board, rather than local government, employees.

CSBs are not part of the Department. The Department's relationships with all CSBs are based on the community services performance contract. The Department funds, monitors, licenses, regulates, and provides consultation to CSBs.

F. State mental health agency leadership in coordinating mental health services

Supporting System Collaboration and Integration

System Leadership Council

The System Leadership Council evolved from the FY 2001 Community Services Performance Contract negotiations, reflecting a desire to include a mechanism in the contract to provide continuity, enhance communications, and address and resolve systemic issues and concerns. The Department, pursuant to provisions in that Performance Contract, established the System Leadership Council in August 2000. The Council includes representatives of CSBs, state facilities, local governments, the State Board, and the Department's Central Office. Subsequent contracts from FY 2002 to the present have continued the Council. For FY 2004, the Council provisions were moved from the Performance Contract to the Central Office, State Facility, and Community Services Board Partnership Agreement. The Agreement states that the System Leadership Council shall, among other responsibilities:

Identify, discuss, and resolve issues and problems;

Examine current system functioning and identify ways to improve or enhance the operations of the public mental health, mental retardation, and substance abuse services system; and

Identify, develop, propose, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost effectiveness of the publicly funded mental health, mental retardation, and substance abuse services system.

The Council serves as a coordinating mechanism to discuss issues and problems from a systemic point of view in a calm environment to reach as much agreement as it can, providing continuity, enhanced communication, and a consistent perspective over time. The Council's work and recommendations affect the organization and delivery of publicly funded services in the Commonwealth. The Council continues to discuss a broad range of issues and support various initiatives, including performance contract and reporting requirements, workforce concerns, aftercare pharmacy and medications issues, and discharge protocols and census management. For instance, the State Pharmacy Task Force established by the Council has significantly affected the operations of the pharmacy and the delivery of psychotropic medications across the state.

Services System Partnerships

The Department took a new approach in developing the FY 2004 Community Services Performance Contract. In collaboration with CSB representatives, Department staff developed the new contract from a blank slate, rather than just revising the previous year's contract. This produced a greatly shortened and more focused FY 2004 Performance Contract. It also produced two new documents, the Partnership Agreement and the Community Services Contract General Requirements Document. Full texts of all three documents are available on the Department's web site at www.dmhmrsas.state.va.us.

The Partnership Agreement describes the values, roles, and responsibilities of the three operational partners in the public mental health, mental retardation, and substance abuse services system: CSBs, state facilities, and the Department's Central Office. It reflects the fundamental, positive evolution in the relationship between CSBs and the Department to a more collegial partnership. It recognizes the unique and complementary roles and responsibilities of the Department and the CSBs as the state and local authorities for the public mental health, mental retardation, and substance abuse services system. The goal of the Agreement is to establish a fully collaborative partnership process through which the CSBs, Central Office, and state facilities can reach agreements on operational and policy matters and issues.

Although this partnership philosophy helps to ensure positive working relationships, each partner has a unique role in providing public mental health, mental retardation, and substance abuse services. These distinct roles promote varying levels of expertise and create opportunities for identifying the most effective mechanisms for planning, delivering, and evaluating services.

Central Office

1. Ensures through distribution of available funding that a system of community-based and state facility resources exists for the delivery of publicly-funded services and supports to Virginia residents with mental illness, mental retardation, or alcohol or other drug dependence or abuse.
2. Promotes at all locations of the public mental health, mental retardation, and substance abuse service delivery system (including the Central Office) quality improvement efforts that focus on individual outcome and provider performance measures designed to enhance service quality, accessibility, and availability.
3. Supports and encourages the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.

4. Ensures fiscal accountability that is required in applicable provisions of the *Code of Virginia,* relevant state and federal regulations, and State Mental Health, Mental Retardation and Substance Abuse Services Board policies.
5. Promotes identification of state-of-the-art programming and resources that exist as models for consideration by other operational partners.
6. Seeks opportunities to affect regulatory, policy, funding, and other decisions made by the Governor, the Secretary of Health and Human Resources, the General Assembly, other state agencies, and federal agencies that interact with or affect the other partners.
7. Encourages and facilitates state interagency collaboration and cooperation to meet the service needs of consumers and to identify and address statewide interagency issues that affect or support an effective system of care.
8. Serves as the single point of accountability to the Governor and the General Assembly for the public system of mental health, mental retardation, and substance abuse services.
9. Problem solves and collaborates with a CSB and State Facility together on a complex or difficult consumer situation when the CSB and State Facility have not been able to resolve the situation successfully at their level.

Community Services Boards

1. Serve as the single points of entry into the publicly funded system of services and supports for Virginia residents with mental illnesses, mental retardation, or alcohol or other drug dependence or abuse.
2. Serve as the local points of accountability for the public mental health, mental retardation, and substance abuse service delivery system.
3. To the fullest extent that resources allow, promote the delivery of community-based-services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability.
4. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
5. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility-based services and local community-based services.
6. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
7. Problem solve and collaborate with State Facilities on complex or difficult consumer situations.
8. Encourage and facilitate local interagency collaboration and cooperation to meet the other services and supports needs of consumers.

State Mental Health Facilities

1. Provide psychiatric hospitalization and other services to consumers identified by CSBs as meeting statutory requirements for admission.
2. To the fullest extent that resources allow, provide services that address the specific needs of individual consumers with a focus on service quality, accessibility, and availability.

3. Support and encourage the involvement and participation of consumers and family members of consumers in policy formulation and services planning, delivery, monitoring, and evaluation.
4. Establish services and linkages that promote seamless and efficient transitions of consumers between state facility-based services and local community-based services.
5. Promote sharing of program knowledge and skills with operational partners to identify models of service delivery that have demonstrated positive consumer outcomes.
6. Problem-solve and collaborate with CSBs on complex or difficult consumer situations.

Core Values

The partners entered into the Agreement to improve the quality of care provided to consumers and to enhance the quality of consumers' lives. While they are interdependent, each partner works independently with both shared and distinct points of accountability, such as state, local, or federal government, other funding sources, consumers, and families, and all partners embrace common core values. The following core values guide the operational partners in developing and implementing policies, planning services, making decisions, providing services, and measuring the effectiveness of service delivery.

1. The Central Office, state facilities, and CSBs are working in partnership; we hold each other accountable for adhering to our core values.
2. As partners, we will focus on fostering a culture of responsiveness instead of regulation, finding solutions rather than assigning responsibility, emphasizing flexibility over rigidity, and striving for continuous quality improvement, not just process streamlining.
3. As partners, we will make decisions and resolve problems at the level closest to the issue or situation whenever possible.
4. Services should be provided in the least restrictive and most integrated environment possible. Most integrated environment means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible (28 CFR pt. 35, App. A, p. 450, 1998).
5. Community-based services and state facility-based services are integral components of a seamless public system of care.
6. The goal of all components of our public system of care is that the persons we serve recover, realize their fullest potential, or move to independence from our care.
7. The consumer's or legally authorized representative's participation in treatment planning and service evaluation is necessary and valuable and has a positive effect on service quality and outcomes.
8. The consumer's responsibility for and active participation in his or her care and treatment are very important and should be supported and encouraged whenever possible.
9. Consumers have a right to be free from abuse, neglect, or exploitation and to have their basic human rights assured and protected.
10. Choice is a critically important aspect of consumer participation and dignity, and it contributes to consumer satisfaction and desirable outcomes. Consumers should be provided with responsible and realistic opportunities to choose as much as possible.

11. Family awareness and education about a person's disability or illness and services are valuable whenever they are supported by the individual with the disability.
12. Whenever it is clinically appropriate, children and adolescents should receive services provided in a manner that supports maintenance of their home and family environment. Family includes single parents, grandparents, older siblings, aunts or uncles, and other individuals who have accepted the child or adolescent as a part of their families.
13. Children and adolescents should be in school and functioning adequately enough that the school can maintain them and provide an education for them.
14. Independent living or community residency in safe and affordable housing with the highest level of independence possible is desired for adult consumers.
15. Gaining employment, maintaining employment, or participating in employment readiness activities improves the quality of life for adults with disabilities.
16. Lack of involvement or a reduced level of involvement with the criminal justice system, including court-ordered criminal justice services, improves the quality of life of all individuals.
17. The public mental health, mental retardation, and substance abuse services system serves as a safety net for individuals, particularly people who are uninsured or under-insured, who do not have access to other service providers or alternatives.

Linkages with Local Government

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community mental health, mental retardation, and substance abuse services to almost 200,000 Virginians annually. Local governments partner with the Commonwealth through the CSBs that they established and maintain and through their financial and other support of services offered by those CSBs. The Department needs to continue communicating with local governments through their CSBs about their concerns and ideas, such as ways to enhance service quality, effectiveness, and efficiency. As demands for services continue to exceed the capacity of the current services system to meet them and as related requirements for more effective management and coordination of services proliferate, new and innovative approaches need to be considered that preserve the strengths and advantages of the current public services system and the state-local partnership, while responding to these new demands.

Linkages with Private Providers

Private provider participation in the services system is another major strength of the public mental health, mental retardation, and substance abuse services system. This participation has grown dramatically over the last six years.

A number of conditions have limited, reduced or jeopardized private provider participation in the publicly funded mental health, mental retardation, and substance abuse services system.

Medicaid State Plan Option and MR Waiver reimbursement rates, with only a few exceptions, have not been adjusted in over 13 years. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis.

Third party insurance coverage for services continues to decline under managed healthcare, in terms of services covered, amounts of services allowed, and amounts paid for services.

A growing proportion of individuals have inadequate or no health insurance coverage.

Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.

There is a perceived or actual resistance by some private providers, especially residential or inpatient providers, to serving individuals receiving CSB services, because of the severity of the individuals' disabilities or lack on information about effective treatment modalities.

Market forces have led to shifts in private sector service provision, despite the obvious and significant public sector needs for particular services. A clear and immediate example of this condition is the marked and continuing reduction in local private psychiatric inpatient hospital beds in some parts of the state that are available to CSBs and the Department. Some providers have ceased offering this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses, such as Comprehensive Services Act residential beds, which may be less costly to operate and more easily reimbursable.

Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.

The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.

Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during implementation that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Interagency Relationships

The Report of the President's New Freedom Commission on Mental Health identified fragmentation as a serious problem at the state level. The Report stated that state mental health authorities have "enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs individuals and families need" (*Achieving the Promise: Transforming Mental Health Care in America*, p. 33). This fragmentation exists for mental retardation and substance abuse services and supports as well.

In an effort to overcome the inherent fragmentation resulting from existing organization and financing of federal and state programs providing services and supports to individuals receiving mental health, mental retardation, and substance abuse services, the Department maintains collaborative linkages, partnerships, and activities with a number of state agencies. These include the Department of Housing and Community Development (DHCD), Department of Rehabilitative Services (DRS), the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), the Department of Corrections (DOC), the Department of Criminal Justice Services (DCJS), the Department of Juvenile Justice (DJJ), the Virginia Department of Health (VDH), the Department for the Blind and Visually Impaired (DBVI), the Department for the Deaf and Hard of Hearing (DDHH), the Department of Education (DOE), the

Virginia Employment Commission (VEC), the Virginia Office for Protection and Advocacy (VOPA), the Virginia Housing Development Authority (VHDA). Following are descriptions of major interagency collaborative activities.

Interagency Councils and Partnerships

Virginia Board for People with Disabilities – The Department is a member of this Board, which is the state's Developmental Disabilities Council and is responsible for reporting to the Governor on a variety of disability issues. The Board also funds ongoing programs such as the Youth Leadership Forum and Partners in Policy Making, both designed to prepare individuals and families to understand disability services systems and become advocates.

Commission on Youth – The Department actively participates on legislative study committees of the Commission on Youth. In the past year the Commission disseminated the *Collection of Evidence Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*. This document is being electronically disseminated across Virginia to families and public and private providers to increase utilization of evidence based services and practices in child and adolescent mental health treatments. This document may be accessed through www.coy.state.va.us.

Comprehensive Services Act (CSA) – The DMHMRSAS Commissioner is a member of the State Executive Council, which meets monthly and sets policy for community services provided pursuant to the Comprehensive Services Act for At Risk Youth and Families (CSA). Department staff are active participants in the State and Local Advisory Team, which is charged in the *Code of Virginia* §2.1-747 with advising the State Executive Council on state and local CSA operations and service delivery. The Department and other state agency participants provide administrative support for the team in the development and implementation of the collaborative system of services and funding authorized under the CSA. This Team meets at least quarterly. A second CSA team, the Training and Technical Assistance Team, assists local and regional communities in planning and developing training to meet the needs of children and families and systemic needs of local agencies. This team meets at least quarterly to determine training needs.

Mental Health Planning Council - This Council, required by P.L. 102-321 as a condition of Community Mental Health Services Block Grant funding, was initially created in 1989. The Council serves as an advocate for adults with serious mental illness and children with serious emotional disturbance and is authorized in P.L. 102-321 to review, monitor, and evaluate the state's mental health system. The Council has 35 members, including mental health individuals, family members, parents of children with serious emotional disturbances, representatives of key state agencies, state mental health facilities, and major mental health advocacy groups. In addition to functioning in an advisory capacity to the Department, the Council guides the Department in developing individual and family education and manages a small budget of $25,000 that is used to support Council activities, including an annual retreat. Each year, the Council prepares an annual report and recommendations to the state, which is submitted to the Center for Mental Health Services as part of the Department's federal block grant application.

Substance Abuse Services Council – This Council, established by the *Code of Virginia*, § 37.1-207, consists of agency directors (or their delegates) representing the Department, VDH, DSS, DOE, DOC, DJJ, DCJS, the Commission on Alcohol Safety Action Programs, four members of the House of Delegates, two members of the Senate, and representatives from key groups

engaged in substance abuse issues (i.e., the VACSB, the Substance Abuse Certification Alliance of Virginia, the Virginia Association of Alcoholism and Drug Abuse Counselors the Virginia Association of Drug and Alcohol Programs the Virginia Sheriff's Association, and the advocacy community). The Council advises and makes recommendations to the Governor, the General Assembly, and the State Board on broad policies and goal and on the coordination of Virginia's public and private efforts to control alcohol and other drug abuse. In preparation for a formal report and interagency plan to be presented to the Governor and the General Assembly, the Council conducted a survey of state agencies and held five of focus groups throughout Virginia to identify critical issues and trends in substance abuse. Critical issues identified include the need for advocacy and education, enhanced collaboration, additional funding, leadership, and service system issues such as access, capacity, continuum of care, and quality of care. This plan will be presented to the Governor and the General Assembly in the Fall of 2003. The Council maintains a website at www.dmhmrsas.state.va.us/sasc/.

Governor's Office for Substance Abuse Prevention (GOSAP) – The Department is actively involved with the Governor's Office for Substance Abuse Prevention (GOSAP), a federal-state initiative funded by the SAMHSA Center for Substance Abuse Prevention. Housed in the Office of the Secretary of Public Safety, GOSAP brings together the Department, VDH, DCJS, DOE, DSS, DJJ, the Department of Motor Vehicles, the Department of Alcoholic Beverage Control, and the Tobacco Settlement Foundation to coordinate Virginia's substance abuse activities for efficient and effective use of resources. GOSAP administers the CSAP State Incentive Grant and the Governor's discretionary portion of the Safe and Drug Free Schools Act grant. GOSAP maintains a website at www.gosap.state.va.us.

Early Intervention (Part C) Interagency Management Team – The Part C Program is an interagency endeavor with an interagency management team as established in *Virginia Code*. This team has representation from the DBVI, DDHH, DSS, VDH, DOE, DMAS, VOPA, and the State Corporation Commission. A representative from the Virginia Association of Community Services Boards also participates with the team. This group guides the program direction in accordance with federal and state policies.

Virginia Advisory Committee on Juvenile Justice – The DCJS Juvenile Services Section, administers three primary juvenile justice federal funding streams allocated to Virginia. In 1994, DCJS implemented a strategy to use these funds along the continuum of juvenile justice, from prevention through community-based interventions to secure confinement. The three funds are: Title V and II of the Juvenile Justice and Delinquency Prevention (JJDP) Act and the Juvenile Accountability Incentive Block Grant (JAIBG) programs. These funds are intended to address the problem of juvenile crime by promoting greater accountability in the juvenile justice system. This Advisory Committee sets priorities for spending, reviews state and local grants, and makes plans to improve juvenile services in Virginia. The Department actively participates in the fall, winter, and spring meetings of the Virginia Advisory Committee on Juvenile Justice. During FY 2002 and FY 2003, the Advisory Committee established mental health services to juvenile offenders as a priority for spending. Many children in Virginia's juvenile justice system have demonstrated mental heath needs. An analysis of juveniles committed to the State's correctional facilities indicated that, in 1998, 47 percent of males and 57 percent of females had identified mental health treatment needs. They also reported a history of substance abuse. (Source: Virginia's Three-Year Plan 2003-2005, Juvenile Justice and Delinquency Prevention Act, the Juvenile Services Section, Department of Criminal Justice Services.) With this priority

designation, CSBs and the Department were able to apply for funds to meet the mental health needs of juveniles and juvenile offenders. In July 2003, the Department received a one-year grant award from the DCJS of $549,825 (including a local and state match) to provide a mental health clinician and case manager in five detention centers. Funds were distributed to five CSBs to provide mental health treatment services, psychiatric evaluations and substance abuse services to juvenile offenders in need of these services.

Virginia Intercommunity Transition Council – This Council promotes successful transition outcomes for youth and young adults with disabilities by providing leadership and innovation in planning and developing services across agencies to meet their employment, education, training, and community services and supports needs. Youth with serious emotional behaviors face many new challenges when they reach young adulthood, including burdens related to seeking employment and advanced education and training and maintaining community life. Far too often, these youth become homeless or unemployed, drop out of school, or end up in the correctional system. In the past year, the Department collaborated with DOE and DRS to provide training to parents, counselors, teachers, and providers to develop and provide comprehensive community-based services to young adults. The VITC will continue to provide technical assistance related to transition planning for these young adults.

Program Improvement Plan Committee of the Child and Family Services Review Task Force – The 1994 Amendments to the Social Security Act authorized the U.S. Department of Health and Human Services to review State child and family services programs in order to ensure substantial conformity with the State plan requirements in titles IV-B and IV-E or the Social Security Act. The reviews cover child protective services, foster care, adoption, family preservation and family support, and independent living. The reviews are designed to help states improve child welfare services and outcomes for families and children who receive services by identifying strengths and needs within state programs, as well as areas where technical assistance can lead to program improvements. To prepare for the federal audit, DSS organized a Task Force of state and local agencies and family organization to conduct a 6-month assessment of the state's programs before the review, determine the sites, and serve as an advisory committee for the development of the Program Improvement Plan after the review. A representative from the Department and the Child and Family Council of the VACSB serve on this Task Force, which meets monthly.

Virginia's review was held during the week of July 7- 11, 2003. The review examined seven outcomes across three domains: safety, permanency, and child and family well being. Virginia's preliminary results indicated nonconformity in meeting the mental health needs of children in child welfare. This outcome failure presents an opportunity for improved services and collaboration between CSBs and local social services departments. The DSS must develop a Program Improvement Plan (PIP) that covers all areas of nonconformity within 90 calendar days of receiving the written notices of nonconformity. During September and October 2003, DSS reviewed the preliminary results with all 130 local social services departments in order to engage their participation in the development of the Improvement Plan. These local departments must conform to the approved PIP. If the State fails to make improvements needed to bring areas of non-conformity into substantial conformity, federal funds are withheld commensurate with the level of the nonconformity. Many of the children in the child welfare system receive services through the CSBs.

Child Fatality Review Team – The Department has continued to serve on the State Child Fatality Review Team, established pursuant to the *Code of Virginia* §32.1-283.1 B. This 16-member

Team develops and implements procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. Team recommendations are used to develop procedures for the review of child deaths; improve the identification, data collection, and record keeping of the causes of child deaths; recommend components for a prevention and education program; recommend training; improve the investigations for child deaths; and provide technical assistance, upon request, to any local child fatality teams that may be established. Team recommendations are used for public health planning, prevention programming, and policy discussions and recommendations. From 1995 - 2001, the Team reviewed child deaths due to firearms, suicide, and unintentional injury. In December 2002, the Committee completed a report on 2001 child deaths due to unintentional injury, suicide, homicide, and natural or undetermined causes. For 2003-2005, the Team will review child deaths related to vehicular violence. The Team meets bimonthly at the Office of the Medical Examiner.

Commonwealth Partnership for Women and Children Affected by Substance Use – The Partnership's membership consists of representatives from VDH, DOE, DSS, DOC, CSBs and contract providers, local departments of social services and health, local housing authorities, the Medical College of Virginia, provider associations, the faith community, and local nonprofit agencies, all organizations that provide services for women and children whose lives have been affected by substance use. The Partnership seeks to identify and resolve barriers to services by seeking resources, encouraging interagency collaboration, participating in community planning and policy development, and coordinating education and training events.

Section II.
Identification and Analysis of the Service System's Strengths, Needs, and Priorities

Adult Mental Health System

Criterion 1: Comprehensive community based services

In December 2002, Governor Warner proposed a multi-year vision to restructure Virginia's mental health services system. The goal of this restructuring process is to achieve a more comprehensive and fully developed system of community-based care. This would also serve to reduce the Commonwealth's reliance on state facilities for services that could be more appropriately provided in the community.

In addition, DMHMRSAS has recently revised its mission to be:

> "We [DMHMRSAS Central Office] provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders. We seek to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals."

Health, mental health, and rehabilitation services

Employment Services

Adults with a serious mental illness face challenging obstacles to obtaining and maintaining competitive employment. The Department intends to address many of these barriers through continuing and broadening its collaboration and coordination with multiple federal and state agencies, entities of local government, universities, public and private providers, consumers, family members, and advocacy groups through implementation of several diverse but coordinated initiatives.

One such initiative is the *Ticket to Work and Work Incentives Improvement Act of 1999* (TWWIIA). The Ticket to Work and Self-Sufficiency Program provides tickets to disabled beneficiaries to take to a certified provider of their choice for rehabilitation and employment services. Virginia beneficiaries started receiving their "tickets" in late fall 2002. Often Virginians with disabilities are reluctant to seek employment because they fear losing their medical and

mental health benefits. The Department has and will continue to collaborate with the Department of Rehabilitative Services (DRS), Department of Medical Assistance Services (DMAS) and other state agencies on grant application opportunities. Virginia's General Assembly helped to support this initiative by passing legislation in 2003 that requires DMAS to apply for a waiver from the Center for Medicare and Medicaid Services. This waiver would serve to implement a Medicaid buy-in for those working Virginians with disabilities whose earnings are too high to qualify for traditional Medicaid comprehensive health care services.

To help educate people with disabilities about their work options, the DRS, in conjunction with the Department, applied for and received a Department of Labor Workforce Coordinating Grant to support the customization of WorkWORLD™ decision support computer software. WorkWORLD™ software helps people with disabilities make critical decisions about gainful work activity and the use of work incentives, taking into account SSI, SSDI, Medicaid, Medicare, Section 8 rental assistance, Auxiliary Grants and Food Stamps.

Virginia's CSBs currently provide some supported employment services but Virginia's *One Community—Final Report of the Task Force to Develop an Olmstead Plan for Virginia* identifies that the current employment services provided to adults with serious mental illness does not match the Evidence-Based Supported Employment/Individual Placement and Supports model. This model calls for an integrated team approach to coordinate the full range of employment, case management and treatment services. The report recommends that Virginia identify and solve the barriers to implementing this Evidence Based Practice. There are joint mental health and substance abuse employment initiatives between the Department and DRS that focus on specialized vocational assistance services in CSB mental health and substance abuse programs. The Department maintains an interagency agreement with the DRS that funds DRS counselors to provide programs addressing employment and community stability through vocational development, work habits, job readiness, and employment follow-along services, along with CSB clinical and social supports. The Olmstead Report calls for increasing these services. In addition, it recommends the development of joint training initiatives among DMAS, DRS, and DMHMRSAS along with public and private providers in relation to employment-related services and supports that could be funded by each State agency.

In another employment-related initiative, in FY 2003, the Department collaborated with numerous entities to support Workforce Investment Board (WIB) grant applications to the U.S. Department of Labor. The Northern Virginia WIB was awarded approximately $600,000 for one year (five year renewable grant) for *Project One Source*. Funds are being utilized to enhance the Northern Virginia One-Stop's capacity to provide coordinated, seamless employment services to adults with disabilities and to ensure a well-trained staff in the One-Stop Centers. In addition, Department staff serves on the Executive Management Council of the project awarded to the Capitol Area Workforce Investment Board (Capitol Area Training Consortium). The Capitol Area WIB was awarded approximately $975,000 for 24 months to enhance the ability of Virginia's One-Stop service delivery system to provide comprehensive employment services to jobseekers with disabilities and to enhance physical and program accessibility of the One-Stop system.

Housing Services

Lack of affordable housing has been cited as the primary cause of homelessness in the U.S. Poor people who have a mental disability are at increased risk for homelessness. The number of Virginians with serious mental illnesses estimated to be homeless or at risk of homelessness is between 12,000 and 20,000. This estimate is based on studies that project between 5 percent (Task Force on Homelessness, 1992) and 8.4 percent (Culhane, 1997) of adults with serious mental illness will become homeless each year. This population is often disengaged from mental health services and in great need of housing and support services.

In an ongoing effort to promote, enhance, and develop housing opportunities for individuals receiving mental health and substance abuse services, the Department has maintained collaborative linkages, partnerships and activities with the Virginia Housing Development Authority (VHDA), the Department of Housing and Community Development (DHCD), the Virginia Interagency Action Council on Homelessness (VIACH), the Virginia Housing Study Commission, CSBs, and public and private housing providers.

There are two primary barriers to the provision of housing for adults with mental disabilities: availability and affordability. In 2001, DHCD and VHDA held a series of housing forums across Virginia to solicit public input on current housing needs in each region of Virginia. Representatives from CSBs were present at most forums and provided important feedback about the housing needs of their consumers. In every regional forum, participants cited a lack of affordable housing; increased demand for special needs housing; and a need for education at the consumer, provider, and community level.

The Olmstead Task Force Report also highlighted the critical importance of assuring the availability of adequate supplies of affordable housing in order to assure that persons with disabilities live as independently as possible in the communities of their choice. The Task Force found that a wide range of community housing stock and models of support are not available because of a lack of adequate subsidies and other factors, and that State agencies must work collaboratively and creatively to make housing available and affordable for Virginians with disabilities under the Olmstead decision.

The Disability Commission, which was formed in 1990 under House Joint Resolution 45 to identify legislative priorities related to Virginians with disabilities, has also increased its focus on the housing needs of people with disabilities in its creation of a Disability Housing Workgroup (including representation by the Department and CSBs) to work with DHCD in developing a Housing Action Plan. Subsequently, the Commission issued a report entitled “Expansion of Affordable, Accessible Housing For Persons With Disabilities And Frail Elders Statewide”.

Educational Services

Psychosocial Rehabilitation and Treatment: DMHMRSAS has supported PSR in CSBs for more than 20 years, including educational components in many of them. In addition, in FY 1996, DMHMRSAS initiated development of psychosocial rehabilitation services in state mental health facilities. Currently all facilities serving adults with mental illness provide these services, which

enable hospitalized persons with mental illness to learn skills that help them to be discharged from inpatient care and to live in communities around Virginia.

The Virginia Human Services Training Center (VHST) has been established through collaboration between DRS, the Department, Piedmont Virginia Community College, and the Region Ten CSB established. VHST is a consumer-provider training program that offers adults living with serious mental illnesses an opportunity to be trained to work in the field of mental health.

Substance Abuse Services

The Department's Office of Substance Abuse Services (OSAS) is undertaking several initiatives to help increase the use of evidence-based practices in CSBs and their contract agencies. OSAS is developing and distributing Guidance Bulletins to the CSBs that identify "best practices" in specific areas of clinical practice and has started publishing a newsletter via its web page. An internal EBP advisory committee has plans to examine best practices for treatment of individuals with co-occurring disorders and consider how to fit these practices into our continuum of care. In collaboration with the Substance Abuse Council of the VACSB, OSAS is developing a manual of core standards that specifically focuses on clinical issues. Finally, OSAS provides regularly scheduled technical support visits to CSBs to assist them in clinical issues, including identifying clinical practice models and assisting with evaluation design.

Medical and Dental Services

The Report of the President's New Freedom Commission on Mental Health indicates that states have relied on the Medicaid program to support their mental health systems and, as a result, Medicaid is now the largest payer of mental health services in the country. Even with this increased reliance on Medicaid funding, the New Freedom Commission Report suggests that the states have missed opportunities to use Medicaid funding because of uncertainties about:

How to cover evidence-based practices,

Which services may be covered under the State Medical Assistance plan,

Which services are allowable under waiver, and

How to use Medicaid funds with other private sources.

Given the importance of Medicaid as a primary source of funding for mental health services, any changes in how the program is structured could have a profound effect on Virginia's mental health services system. Medicaid is by far the largest single source of funds for community services across the state. DMHMRSAS works in collaboration with DMAS to increase the financial incentives to serve people with mental illness in the community whenever possible. Currently, covered mental health community services include:

- intensive in-home services for children and adolescents;
- thereapeutic day treatment for children and adolescents, day treatment/partial hospitalization;
- psychosocial rehabilitation;

- crisis intervention;
- intensive community treatment;
- crisis stabilization;
- mental health support services; and
- community-based residential services for children and adolescents.

CSBs work with their consumers to identify those eligible for Medicaid and to assist them in their application for Medicaid. This opens up a wide range of medical, dental, and mental health services that would otherwise not be available to them. In addition, the Department has collaborated with the Virginia Association of Free Clinics (VAFC) in order to open a dialogue about areas of mutual interest. According to a survey conducted by the VAFC in September 2003, approximately 250 persons per week are seeking access to mental health services through Virginia's Free Clinics because services are not available from CSBs. These individuals most often need medications and outpatient counseling. Department staff and CSB physicians also participated with the Medical Directors and staff of Virginia's Free Clinics in a continuing medical education program sponsored by the Medical Society of Virginia which focused on delivering mental health care to the medically underserved. DMHMRSAS and CSB staff also presented to VAFC medical directors on issues related to accessing CSB services.

In many areas of Virginia, the most significant barrier to primary health care is the lack of providers in the individual's community. The Virginia Primary Care Association is devoted to improving access to primary care by increasing the number of practitioners in underserved areas of the state. One of their goals is to provide primary care to uninsured Virginians within a reasonable travel distance. They do so through their Scepter program, which places medical students and other primary health care professional students in Community Health Centers for two to six week rotations; through organized recruitment efforts; and by working with communities to develop solutions for improving access.

Support Services

Other types of supports for persons with serious mental illness include*:*
- Peer support
- Primary health care (for example, Medicaid)
- Housing and housing assistance (for example, rental assistance)
- Income assistance (for example, SSI/SSDI and food stamps)
- Transportation
- Family Support

Case Management Services

Case Management services assist individuals and their family members in accessing needed services that are responsive to individual needs. Services available include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain

needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs. In SFY 2002, 38,599 consumers with mental health disorders and 16,228 consumers with substance use disorders received case management services.

Services for persons with Co-occurring Substance Abuse and Mental Health Disorders

Individuals with co-occurring disorders present challenges for the treatment system. Program barriers for serving persons with co-occurring disorders include a lack of clear service models, administrative guidelines, contractual incentives, and quality assurance procedures and outcome measures needed to implement dual diagnosis services. The Department's role in addressing this challenge is to assure that there is a collaborative and integrated response to the needs of individuals with co-occurring disorders.

DMHMRSAS is presently engaged in several activities that address the needs of persons with co-occurring disorders. The Mid-Atlantic Technology Transfer Center operates the Virginia Institute for Professional Addiction Counselor Training and provides training for substance abuse services professionals throughout the state. Knowledge acquisition of providers is enhanced through Guidance Bulletins distributed to all CSBs. These efforts afford an opportunity to incorporate standards related to treatment of persons with co-occurring disorders. Recently DMHMRSAS submitted a revised State Incentive Grant for the Treatment of Persons with Co-occurring Substance Related and Mental Disorders, which, if funded, would supplement the above initiatives.

Despite these efforts, Virginia does not have a distinctive, planned, comprehensive and coordinated approach to delivering services to individuals with co-occurring disorders. Statutes and regulations governing the use of the Mental Health Performance Partnership Grant include services for dually diagnosed individuals, however these funds constitute only 2 percent of Virginia's allocation to CSBs. There are no mandated guidelines or existing forums that promote minimum acceptable standards for delivery of care for persons with co-occurring disorders and the Department does not currently have a comprehensive approach to training Central Office or CSB staff in the provision of coordinated and integrated services to individuals with co-occurring disorders.

Other activities leading to reduction of hospitalization

Programs of Assertive Community Treatment (PACT): PACT teams provide intensive treatment, rehabilitation, and support services that reduce state hospital utilization. Use of PACT programs has reduced the use of inpatient services by these consumers by over 85 percent and has achieved other positive consumer outcomes, such as reduced involvement in criminal justice and greater housing stability.

Use of New Generation Medications: Since FY 1997, the Governor and General Assembly have supported increased use of new generation medications for persons with serious mental illness with the addition of $16 million in new funds. These medications are more effective and have

fewer side effects, thereby enhancing compliance and clinical outcomes, which helps reduce the use of institutional care.

Discharge Assistance Project: In FY 1998, DMHMRSAS initiated the Discharge Assistance Project (DAP), which serves approximately 380 persons with mental illness who were unnecessarily residing in DMHMRSAS hospitals due to unusual barriers to discharge. Under this initiative, individualized community service plans were developed, funded, and implemented so that these persons can now live in the community.

Acute Care Pilot Project: In FY 1999, the CSBs in the Richmond/Tri-Cities area entered into arrangements with community hospitals in to eliminate the use of acute care at Central State Hospital (CSH) by providing these services in the community hospitals. The CSBs, CSH, and the DMHMRSAS have jointly managed the utilization of these beds. This practice has allowed consumers who need hospital care to be treated closer to home and with shorter lengths of stay.

Discharge Protocols: In FY 2000, DMHMRSAS initiated development of standardized discharge protocols for use by all CSBs and state mental health facilities and provided extensive training in the use of the protocols. The protocols help clinicians focus on and identify specific community service and support needs for consumers ready to be discharged. The resulting discharge plans are more individualized, which results in a better match between consumers' needs and services provided, and in better consumer outcomes.

Quantitative targets for Criterion 1 are the performance measures selected in Section III:

- Readmission Rate
- Number of evidence-based practice services
- Persons receiving evidence-based practice services
- Positive perceptions of outcomes
- Bed Day Rate

Criterion 2: Mental Health System Data Epidemiology

Individuals Who Have a Serious Mental Illness

A mental disorder is broadly defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (the *DSM* IV) as:

> A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Serious Mental Illness in Adults: Three dimensions define serious mental illness:

- Diagnosis of serious mental illness in the *DSM IV*, including schizophrenia and related disorders, affective disorders such as major depression and bipolar disorders, antisocial

and borderline personality disorders;

- Severe, recurrent disability in two or more areas of life functioning, i.e., employment, meeting basic shelter and support needs, interpersonal relations, self-care and activities of daily living, as well as violating community norms; and
- Treatment history that includes intensive services or services needed for an extended duration.

Total population prevalence estimates are based on the 2000 Census for Virginia. The 2000 Census was used because it provided the most current age cohorts. According to the Report of the New Freedom Commission on Mental Illness, *"Achieving the Promise: Transforming Mental Health Care in America,"* (2003), in a given year, about 5 to 7 percent of adults have a serious mental illness, based upon nationally representative studies. The NHSDA survey found an overall rate of past year serious mental illness of 7.3 percent of all adults aged 18 and older. By applying these age-specific rates to appropriate cohorts of Virginia's adult population, using 2000 Census data, an estimated 394,748 Virginia adults have a serious mental illness.

Individuals Who Have a Substance-Use Disorder

Substance-related disorders can be categorized as either substance *use* disorders (substance dependence and substance abuse) or substance-*induced* disorders, which include intoxication, withdrawal, delirium, psychosis and other conditions caused by substance use. Substances can include prescription drugs, over-the-counter drugs, illegally manufactured drugs, alcohol, and tobacco. Substance *use* disorders may or may not be related to abuse or dependence on a substance.

- Substance *dependence* is characterized by continued use of the substance in spite of "significant substance-related problems" with "a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behavior" (DSM IV).
- Substance *abuse* is characterized by "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances (DSM IV).

Prevalence estimates of substance dependence (addiction) in the past year for individuals who are age 12 and over were obtained from the 2001 National Household Survey on Drug Abuse (NHSDA). Using 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated prevalence of dependence in Virginia. The estimated prevalence of adults and adolescents reporting past year dependence on any illicit drug is 1.6 percent, or 94,701 Virginians. The estimated prevalence of past year alcohol dependence is 2.4 percent, or 142,052 Virginians. The total estimate in that time frame for any illicit drug or alcohol dependence is 3.6 percent, or 213,073 Virginians.

Individuals Who Have Co-occurring Substance Use Disorders and Mental Illness

Research suggests that as many as half of the adults who have a diagnosable mental disorder will also have a substance use disorder during their lifetime. (Kessler et al. 1994, Office of Applied Studies 2003, Regier et al. 1990) In 1998, SAMHSA estimated that 7.2 million persons between the ages of 18-54 with co-occurring disorders are living in households. This equates to approximately 191,210 adults in Virginia.

Quantitative targets to be achieved are the two performance measures established in Section III:

- Number of persons served by the state mental health authority
- Treated prevalence of serious mental illness

Criterion 3: Children's Services

Not Applicable for Adult Services

Criterion 4: Targeted services to rural and homeless populations

Rural Populations

In 2000, the DMHMRSAS Central Office participated in a regional summit co-sponsored by SAMHSA and HRSA, Bureau of Primary Health Care, and National Health Service Corps that focused on "Ensuring the Supply of Mental and Behavioral Health Services and Providers." In response, the Department entered into a partnership with the Virginia Department of Health, Virginia Primary Care Association, and the Virginia Rural Health Resource Center. The Partnership sponsored a two-day conference in September 2002 focusing on the integration of behavioral health into primary care.

Homeless Populations

The *Analysis of Housing Needs in the Commonwealth* (Virginia Department of Housing and Community Development and the Virginia Housing Development Authority, November 2001) reports that "demand for affordable housing among people with disabilities will continue to increase rapidly due to a number of factors including: the unresolved need to provide community living alternatives to institutional placement, the continued increase in life expectancy among disabled people, and the advanced age of many family care givers… [Yet,] the declining ratio of deep rental subsidy units to renter households in metropolitan housing markets will pose a severe challenge to addressing the needs of disabled people, particularly given the extremely large gap between prevailing rents and the incomes of most disabled people…"

This lack of affordable housing has been cited as the primary cause of homelessness among people with disabilities. Poor people who have a mental disability are at increased risk for homelessness. The number of Virginians with serious mental illnesses estimated to be homeless each year is between 12,000 and 20,000. This is based on studies that project between 5 percent (Task Force on Homelessness, 1992) and 8.4 percent (Culhane, 1997) of adults with serious mental illness become homeless each year. This population is often disengaged from mental health services and in great need of housing and support services.

Studies show that between 5% (Task Force on Homelessness, 1992) and 8.4% (Culhane, 1997) of adults with serious mental illness become homeless every year. In Virginia this amounts to between 12 and 20,000. Virginia is committed to providing services to individuals with serious mental illness who are homeless and is a recipient of Projects for Assistance in Transition from Homelessness (PATH) formula grant. This grant provides funds for outreach to persons who are homeless and have serious mental illness across the state. In FY 2003, these organizations provided outreach to 6,736 homeless persons and 2,425 (36 percent) of them were enrolled in PATH services. At enrollment, most (66 percent) were unengaged with the mental health system and without any shelter (77 percent). PATH-funded staff helped 954 get into shelters and 748 were helped with housing assistance applications, 396 were placed in housing, and 772 were placed in mental health services. For FY 2004, Virginia is awarded $861,120 in PATH funds. This is an increase in funds from last year and has enabled Virginia to plan for additional PATH sites. There are currently eighteen PATH sites in Virginia, with three more in the planning stages.

The performance measure chosen for Criterion 4 is level of shelter, housing and mental health services to homeless adults with serious mental illness.

Criterion 5: Management Systems

DMHMRSAS is the primary funding source for public mental health services in Virginia. Other revenues include Medicaid, other third-party payments, Federal grant funds and local tax revenues. The community mental health system is underfunded to provide all needed community-based services. This fact underlines the significance of the Community Mental Health Services Block Grant funds as part of the total resources used for community services. Mental Health Block Grant funds are primarily used in Virginia to support and develop services through CSBs. CSBs use the Block Grant funds, in conjunction with other state and local funds, to maintain and expand the array of community-based services for adults with serious mental illness.

The manner in which the State intends to expend the mental health block grant is described in the budget table on the following page.

PLACEHOLDER FOR BUDGET

Training in Emergency, Medical and Dental Services

A number of initiatives and planning activities are underway in Virginia to assure that training is provided for staff and providers of emergency health services and medical and dental services for children and adults regarding the mental health needs of their clients. DMHMRSAS works with the Virginia Hospital and Healthcare Association and the college of Emergency Physicians to identify, treat and stabilize the medical conditions of individuals prior to their admission to state psychiatric hospitals. CSBs make referrals to community providers of medical and dental services and case managers make every effort to locate medical and dental resources for indigent individuals.

The tragedy of September 11, 2001 increased awareness of the importance of effective mental health interventions for individuals who are affected by mass violence, terrorist attacks and other crises. Virginia was fortunate to receive grant funding from CMHS to assist in efforts to respond to this need. Some of the activities under this grant will enable providers of mental health services to receive training on how to ameliorate the psychological effects of disasters and terrorist events. A multi-media package, which has utility for mental health and/or medical personnel, will be produced and made available on an ongoing basis at each of the community services boards. The multi-media package will serve as a training resource to communities on many topics, including appropriate mental health responses to victims of terrorism, resilience to stress, stress management, the grieving process and grief interventions. Through these efforts, Virginia will increase awareness of the most recent information about mental health responses to mass trauma and increase the ability of "first responders" to respond to mental health needs.

The performance measure chosen for Criterion 5 is the percentage of SMHA-controlled expenditures used to support community programs.

Strengths

In spite of budget cuts, Virginia managed to serve more individuals in the community last year. Virginia displays strengths in the following areas.

Community-based Services

- The expansion of community-based Medicaid services has enhanced the comprehensive system of care.
- Restructuring efforts underway are diverting costly inpatient resources into valuable community-based alternatives for consumers.
- We continue to work with DMAS to make sure that we maximize opportunities to provide community-based, recovery-oriented services.
- Although Virginia does not have a PACT service in its state Medicaid plan, efforts are under way to make it possible to bill for PACT services under Virginia's Intensive Community Treatment Service.

Homeless Population

- States are required to match PATH funds with cash or in-kind resources at a minimum of 33 percent, but Virginia's local providers have always contributed more than that amount to this much-needed program.

Training

- Virginia supports a number of training programs for providers of mental health and emergency services including: the Institute of Law Psychiatry and Public Policy, Emergency Services Conference, United States Psychosocial Rehabilitation Services Conference (Virginia Chapter), and other recovery-oriented training.

Weaknesses

Medicaid

- Although Medicaid is the largest source of funding for mental health services, DMHMRSAS does not have significant policy-making authority.
- DMHMRSAS and DMAS do not jointly establish goals, policies and plans for Medicaid service delivery.
- Virginia has not taken advantage of opportunities used by many other states to expand critically needed services that could be covered under Medicaid.

Service Delivery

- Not all CSBs offer all services, which results in an uneven continuum of care

Unmet Service Needs and Critical Gaps

Existing Waiting Lists

- CSB and state mental health facility waiting lists demonstrate that many consumers are not receiving the services that they need.

Geriatric Population With Serious Mental Illness

- Virginia does not have an organized system of specialized services for the geriatric population with serious mental illness.
- As the population ages, people with mental illness may also begin to experience complications from a variety of physical illnesses. Community mental health programs should prepare for these changes by analyzing their service arrays for their appropriateness for an older population. CSBs are likely to see an increasing number of individuals with mental illness who will require mental health supports to enable them to reside in a nursing home or assisted living facility.
- The aging population also will require some changes in the state's Medicaid benefit package. To avoid over reliance on state inpatient care for these individuals, it will be important to create more flexible Medicaid reimbursement for community-based services that are appropriate for older individuals with mental illness.
- If abuse of alcohol and legal drugs among older Virginians were to continue at the same rate as their U.S. counterparts (17 percent), demand for specialized treatment services

could be 1.5 times greater in 2030 because of population growth. (Gfoerer and Epstein, 1999, in DASIS 2001)

Persons with Co-occurring Substance Use and Mental Illness

- Virginia does not have an organized system of specialized services for individuals with co-occurring substance use disorders

Rural Areas

- Not all CSBs offer all services resulting in an uneven continuum of care
- There is a severe shortage of psychiatrists in rural areas.

Priorities and Plans to Address Unmet Needs

Waiting Lists for Services at local CSBs and State Mental Health Facilities

- The biennial Comprehensive State Plan describes Virginia's unmet service needs and is used as part of Virginia's budgetary process to document the need for increased funding. Waiting lists help to support the need for funding increases.

Geriatric Population with SMI

- A workgroup was established to focus on the geriatric population. The workgroup will submit its recommendations to the Commissioner on August 2, 2004. Recommendations include creation of new geriatric services in the community, coordination between state agencies, and specialized funding for the geriatric population.

Persons with Co-occurring Substance Use and Mental Illness

- Improved coordination between the Mental Health and Substance Abuse Offices at the state level. Promotion of coordinated community services. Virginia has applied for a State Indicator Grant Data Infrastructure Grant for Co-Occurring Disorders to support our efforts in these areas.
- The Department is hosting a Homeless Services Conference in October

Mental Health in Rural Areas

- DMHMRSAS has incorporated the following steps to address the need for increased services in rural areas into its Comprehensive State Plan for 2004-2010:
    - Convene a workgroup of state facility and CSB leaders to identify current and projected areas of service need.
    - Assess the capacity of current medical and clinical staff to meet the specialized service needs of individuals served by CSBs in rural and clinically underserved areas.
    - Identify the availability of specialized medical and clinical expertise in state facility programs by state facility service area.
    - Develop strategies to provide state facility specialized medical and clinical staff for treatment and consultation services to CSBs that have current and projected shortages.

- Use state facility medical and clinical specialists to provide training to CSB personnel in identified areas of need, using interactive telecommunication networks and video technology.
- Advocate Federal regulatory revisions to assess per capita allotments fairly within state allocations in distributing transportation funding so that amounts would be allotted equitably among rural and urban populations.

Recent Significant Achievements Towards a Community-Based Mental Health System of Care

Restructuring Virginia's Mental Health System

- Virginia's recent restructuring of the state's mental health system included diversion of funds from inpatient state mental health facility to local acute inpatient care and a variety of other community services.
- Consumers, families and other stakeholders have played an important role in strategic planning statewide.
- Virginia has developed new partnerships with private providers and community hospitals. The 2003 General Assembly passed Appropriation Act language directing the DMHMRSAS to implement three regional reinvestment projects. Each project proposes different strategies for transferring facility resources into the community to expand community-based care and treatment for individuals who would otherwise require state facility services. Progress to date has included State Hospital diversion projects, plans for increased jail-based services, expansion of the types of community mental health services and an increased focus on improving access to geriatric mental health care.

Rural Populations and Homelessness

- DMHMRSAS hired a PATH coordinator.
- PATH funds were increased allowing the addition of 3 new PATH sites.
- Representatives of several state agencies, including DMHMRSAS, participated in a Homelessness Policy Academy.
- The Disability Commission made housing and homelessness one of their priorities.
- Virginia DMHMRSAS submitted a Real Choice Systems Change Grant to establish a Medicaid waiver for high users of inpatient services with housing problems.

New Funding

- New funding was appropriated in the FY 05-06 Budget for the following programs:
    - Discharge Assistance Projects (DAP) (77 slots)
        - $3,600,000 in FY 05
        - $5,400,000 in FY 06
    - Programs of Assertive Community Treatment (PACT) (3 teams)
        - $2,000,000 in FY 05
        - $2,600,000 in FY 06

- Inpatient Purchase of Service (POS)
  - $1,000,000 in FY 05
  - $1,000,000 in FY 06

Comprehensive Community-based Mental Health System of the Future

The Department has a new vision of "a community-based system of services that promotes self-determination, empowerment, recovery, and the highest possible level of consumer participation in work, relationships, and all aspects of community life." The foundation of this vision includes:

1. Self-determination, empowerment and recovery,
2. Expanded quality of services including EBPs,
3. Access to care regardless of ability to pay,
4. Accountability through stakeholder monitoring of performance measures,
5. Partnerships with other local and state agencies,
6. Coordination of care,
7. Appropriate funding to address consumer needs, and
8. Efficient use of resources.

Children's Mental Health System

Criterion 1: Comprehensive community based services

In the past year, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services two child-specific planning groups of major stakeholders have completed their work to identify the strengths and weakness of the system of care in Virginia. These entities are:

- The 2003 Policy and Plan to Provide and Improve Access to Mental Health Mental Retardation and Substance Abuse Services for Children, Adolescents and Their Families and Child; and
- The Child and Adolescent Special Population Workgroup of the Restructuring Virginia's Mental Health, Mental Retardation and Substance Abuse System initiative.

Health, mental health, and rehabilitation services

Housing Services
Virginia is in receipt of a "Projects for Assistance in Transition from Homelessness" (PATH) formula grant. Any homeless family with a parent or child who suffers from mental illness who lives in the catchment area for the nine available PATH sites is eligible to apply for assistance.

Educational Services
One of Virginia's priorities includes providing transitional services to youth with serious emotional disturbance who are moving from school to work settings. Successful integration of such services is dependent upon communication between the Department and other state agencies providing education and work assistance to children and adults. Virginia DMHMRSAS has existing relationships and cooperative agreements with agencies such as the Virginia Board for People with Disabilities, Department of Rehabilitative Services, Department of Education and the Virginia Employment Commission.

Substance Abuse Services
In FY 2003, DMHMRSAS received a Juvenile Accountability Incentive Block Grant of $104,000, which is being used in a pilot study in five localities. Two full-time staff members were hired for each of the five detention centers including a mental health/substance abuse therapist and case manager. Goals of the grant include assessment of all children to identify those in need of mental health/substance abuse services, provision of services and coordination of care with local community service boards upon discharge from the detention center.

Medical and Dental Services
CSBs work to promote FAMIS to the parents of children and adolescents that they serve. FAMIS is Virginia's health insurance program for children whose families do not qualify for Medicaid benefits. It provides access to quality health services for children of working families. Similar to the adult mental health system, the most significant barrier to primary health care in some areas of Virginia is the lack of local providers. The Virginia Primary Care Association's Sceptor program places medical students and other primary health care professional students in Community Health Centers for two to six week rotations where they provide medical care to adults, children and adolescents. They also have organized recruitment efforts and work with communities to develop solutions for improving access.

Support Services
Case managers at local community services boards assist families obtaining housing and income assistance as well as assistance in getting children to the CSB. The Department also funds a variety of family support and prevention services. Parents and Children Coping Together (PACCT) has trained over 100 family members and caregivers of children with serious emotional disturbance. The block grant has provided financial support to PACCT. Its Family Involvement Workshop provided information about the service system in Virginia and taught the skills needed to effectively access services for children in need. A Family Leadership train-the-trainer workshop was conducted to train family members in the skills needed to conduct their own Family Involvement Workshop. A toll-free telephone number has been maintained to provide information and referral for mental health services for children across the state. Quarterly newsletters concerning mental health services for SED children have been published and distributed across Virginia. Additional strategies are being developed to be responsive to the needs of parents of children with serious emotional disturbance. The Department also funds 12 science-based prevention programs for families, including services for new parents, for Head Start children and their parents, and families with children and adolescents.

Case Management Services
Case Management services assist individuals and their family members in accessing needed services that are responsive to individual needs. Such services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs. In FY2003, 7,390 children and adolescents received case management services.

Services for Children and Adolescents with Co-occurring (Substance Abuse/Mental Health) Disorders
Virginia has continued to focus on integrating services for this population. Meeting the unique needs of this population through an organized system of community-based care is a challenge that is being addressed at the state government level and at the community service level. To support these efforts, Virginia has applied for a State Incentive Grant for Persons with Co-Occurring Substance Abuse and Related Disorders (COSIG). Continued coordination between the mental health and substance abuse offices of DMHMRSAS and between DMHMRSAS and local service providers will be essential to the success of these efforts.

Other activities leading to reduction of hospitalization
Discharge Protocols: Standardized discharge protocols are in use by all CSBs and state mental health facilities. The protocols assist in the identification of specific community service and support needs for consumers ready to be discharged.

Criterion 2: Mental Health System Data Epidemiology

Children and Adolescents with Serious Emotional Disorders
A mental disorder is broadly defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (the *DSM* IV) as:

> A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment of one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

The methodology for estimating prevalence of serious emotional disturbance was obtained from "*Prevalence of Serious Emotional Disturbance: An Update*" (Friedman et. al., *Mental Health, United States 1998*). Data were insufficient to make prevalence estimates for children younger than nine. This study projects a prevalence rate of serious emotional disturbance and substantial functional impairment in the range of 9 to 13 percent. The prevalence rate of serious emotional disturbance and "extreme functional impairment," was projected to be in the range of 5 to 9 percent. Using the 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated number of children and adolescents between 9 and 17 years of age with a serious mental illness. Between 80,017 and 97,801 Virginia children and adolescents

have a serious emotional disturbance. Of these, between 44,455 and 62,237 have serious emotional disturbance with extreme impairment.

Children and Adolescents Who Have Substance Use Disorders
A review of 2002 National Household Survey on Drug Use and Health (formerly the National Household Survey on Drug Use) data suggests that the use of illicit substances (e.g., cocaine and heroin) and the non-medical use of prescription pain relievers and stimulants, particularly among youths and young adults, are increasing. Alcohol use has been increasing steadily since 1990, with youth under age 18 accounting for much of the increase. Adolescent use nearly doubled, from 2.2 million in 1990 to 4.1 million in 2000, with gender distribution about equal. Virginia has a significant number of youth at risk for substance use disorders. According to the 2000 Virginia Community Youth Survey (2002), 44.2% of high school students report alcohol, tobacco or drug use in the past 30 days while 17.7% of middle school youth report use in the past 30 days.

Children and Adolescents With Co-occurring Substance Use and Mental Illness
A growing body of empirical evidence estimates a prevalence rate as high as 50 percent for the co-occurrence of alcohol and other drug use among adolescents with mental health disorders.

Criterion 3: Children's Services

Since 1987, the Department of Mental Health, Mental Retardation, and Substance Abuse Services has worked to developed a statewide focus for the development of local systems of care for children, adolescents and their families. The Core Services provided by the Community Services Boards are emergency, prevention and early intervention, outpatient and case management, day supports, residential, inpatient hospitalization. Only two of these services are mandated: emergency services and case management, subject to funds available. CSBs offer varying combinations of the six core services with specialized emphasis on children and adolescents.

The Comprehensive Services Act (CSA) is the statewide structure that includes state and local levels to encourage a collaborative participation and planning process to meet the services needs of all youth. The strength of this system is the collaborative structures and the pooling of funds to provide services to meet the multiple needs of youth. The weakness of the CSA is lack of a system perspective to developing policy and procedures, lack of family involvement at the policy and planning levels, lack of locally developed services to meet the multiple needs of children and their families, and over-reliance on services provided in residential facilities.

In 2003, the general assembly passed a bill requiring that the DMHMRSAS, the Department of Medical Assistance Services, and the Department of Juvenile Justice Services, in cooperation with the Office of Comprehensive Services, Community Service Boards, Court Service Units, and other stakeholders develop an integrated policy and plan to provide and improve access by children, including juvenile offenders, to mental health, mental retardation and substance abuse services. The annual plan identifies services needed by children, the cost and source of funding for the services, the strengths and weaknesses of the current delivery system and

recommendations for improvement. In addition, the plan is charged with making recommendations regarding prevention, intervention, and treatment for high-risk children and families in rural localities.

Criterion 4: Targeted services to rural and homeless populations

Rural Populations
Twenty-three of the 40 Community Services Boards provide services to persons living in the rural areas of Virginia. Community services boards vary according to budget size and population density. The services and programs of rural community services boards to children vary as much as the funding. Many of CSBs in the rural areas do not have the infrastructure to support services to children in the rural areas. In addition, the CSA funding stream often prevents rural localities from developing local programs for children who are often referred to private residential treatment facilities for services. Additional funding appropriated by the General Assembly will help alleviate this problem.

Homeless Populations
As stated under Criterion 1, homeless families with a parent or child who suffers from mental illness who live in the catchment of one of the nine PATH sites are eligible to apply for assistance under Virginia's Projects for Assistance in Transition from Homelessness (PATH) formula grant.

Criterion 5: Management Systems

In April 2004, the DMHMRSAS created the Office of Child and Family Services to improve the organization of services within the Department to provide leadership for services and issues pertaining to children and their families on a statewide. The Office of Child and Family Services provides leadership, direction, management and support for integrated services for children and adolescents with mental health, mental retardation and substance abuse disorders and their families. It will establish and strengthen collaborative partnerships with colleagues within DMHMRSAS, other state agencies, state legislature, public and private providers, consumers and families, advocates and other stakeholders and their respective organizations.

Goals:

- To develop a seamless system of care that integrates services across disciplines
- To partner with stakeholders working to improve services for children
- To develop policies that promote children and family services
- To address gaps in existing services
- To develop new services using evidence based practices and expand existing evidenced based models
- To increase family involvement on committees, councils, and task forces addressing children issues
- Increase funding for children services
- To showcase services for children with mental health problems that are working in the Commonwealth.

Strengths of Virginia's Current Mental Health System

Virginia has a strong system of collaborative partnerships to improve and expand services through the state for infants, toddlers, children and adolescents and their families. The state has a statewide interagency early intervention system that provides services to infants and toddlers with disabilities across all disabilities. The state has had the Comprehensive Services Act network in place since the early 1990's. This system created a collaborative network of services and funding for mandated children in foster care of special education. The 2004 General Assembly added $2,000,000 of new state general funds to be used for provision of mental health services to children and adolescents with serious emotional disturbance and related conditions who are not mandated for services under the CSA.

The DMHMRSAS is the lead agency for Part C in Virginia. In August 2003, the Department of Mental Health, Mental Retardation, convened a group of stakeholders and Substance Abuse Services to examine Virginia's Part C system, identify the system's unique strengths and challenges, and make recommendations about infrastructure changes to improve Virginia's Part C system. Virginia's Part C system is faced with a number of significant challenges including significant fiscal crisis. The number of children served through Virginia's Part C system has increased almost 30% since 2000 without any corresponding increase in State General Funds. In addition, public and private insurance reimbursement rates have fallen and other federal funding through DSS and unspent Part C funds have been eliminated.

- An Office of Child and Family Services has been established within DMHMRSAS to coordinate and promote service systems for all children, including those with serious emotional disturbance.
- The Comprehensive Services Act for At-Risk Youth and Families was implemented in state fiscal year 1994. The state has had ten years of cross agency collaborations related to the system of care.
- Additional funds were appropriated by the General Assembly in 2004 to serve children and adolescents who are not mandated for services under the CSA.
- There is local flexibility in service provision, established by the CSA and the establishment of local mental health centers.
- Children's mental health advocacy is strong in Virginia, led by several groups that are represented on the Mental Health Planning Council.
- There are several Virginia universities with the capability to train a competent workforce of professionals.

Weaknesses of Virginia's Current Mental Health System

System-related

- Lack of coordination among agencies in developing policies, procedures and services to allow better access to services.

- Funding for children's services is not coordinated across state agencies.

Service Provision

- Children with mental disorders involved in the juvenile justice system are not adequately served.
- Increasing numbers of children are aging out of services funded by the Comprehensive Services Act. Many of these children are being served in out-of-state placements because there are no services appropriate for them in Virginia.
- There is a critical shortage of psychiatrists and psychologists.
- There are geographic inequities in the available types and amounts of mental health services for children and adolescents.
- Virginia has not taken full advantage of existing opportunities exist to expand services for children and adolescents that could be covered under Medicaid.

Unmet Service Needs and Gaps

CSB Waiting Lists

On April 11, 2003, there were 994 children or adolescents with or at risk of serious emotional disturbance who were receiving some but not all recommended mental health CSB services. There were 320 who were not receiving any CSB mental health services. There were 211 children or adolescents with substance dependence or abuse who were receiving some but not all recommended CSB services. There were 76 who were not receiving any CSB services.

Hospital Beds

Children's public beds dropped from almost 200 to 64 beds in 1990. The system only has beds available through Commonwealth Center (48) and South Western Virginia Mental Health Institute Adolescent Unit (16) to serve those children and adolescents in crisis.

Substance Abuse

A review of 2002 National Household Survey on Drug Use and Health data suggests that the use of illicit substances and the non-medical use of prescription drugs, particularly among youths and young adults, are increasing. Alcohol use has been increasing steadily since 1990, with youth under age 18 accounting for much of the increase. Adolescent use nearly doubled, from 2.2 million in 1990 to 4.1 million in 2000, with gender distribution about equal. Virginia currently does not have the capacity to serve the population of children and adolescents who need specialized substance abuse services.

State's Priorities and plans to address unmet needs

Waiting Lists

Virginia has secured additional funding to be used for provision of services to children who are not mandated for services under the CSA. This expansion of services will help decrease the number of children and adolescents who are currently on waiting lists.

Hospital Beds
Virginia is working with local private hospitals to provide services to children and adolescents in crisis, which will allow them to receive services close to their home.

Substance Abuse
Virginia participates in the *Commonwealth Partnership for Women and Children Affected by Substance Use.* The Partnership's membership includes representatives from local and state agencies, mental health providers, medical providers and other stakeholders. The Partnership seeks to identify and resolve barriers to services. There are also plans to expand the array of adolescent detoxification and treatment services available.

Recent Significant Achievements

The 2000-2002 Appropriation Act included language (Item 329-G) directing the Department and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, CSBs, and court service units, to develop an integrated policy and plan, to provide and improve access by children to mental health and mental retardation services. The Department established a workgroup representing CSBs, state agencies, parents, and other partners to identify service needs and develop the *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Services for Children, Adolescents and Their Families,* hereafter referred as the 329-G Report. General recommendations included:

- Integrate services across disciplines and agencies.
- Implement statewide training on child mental health issues.
- Develop new services and address gaps in existing services.
- Increase the number of board certified/eligible child psychiatrists and trained clinical psychologists.

The Child and Adolescent Special Population Work Group met for the first time on August 8, 2003 to make recommendations to enhance community and facility services to support children and adolescents and their families. The Work Group discussed and supported the *Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs (*Virginia Commission on Youth, 2003) and the 329-G Report. Five groups were formed to make budget recommendations related to: best practices; capacity building; service integration; needs of special populations; and hospital, residential, and detention center facility needs.

Another significant accomplishment was the award of a one-year grant of $549,825 (including a local and state match) to provide a mental health clinician and case manager in five detention centers. Funds were distributed to five CSBs to provide mental health treatment services, psychiatric evaluations and substance abuse services to juvenile offenders in need of these services.

Future Comprehensive community-based public mental health

Virginia's behavioral health services system should provide seamless access to services for child and families to promote the well being of children and reduce the incidence and severity of behavioral health problems.

This vision could be accomplished by the following:

- Agency collaboration at state and local levels
- Adequate funding
- Adequate services/treatment that are evidence-based and provided by qualified professionals
- No child's needs go un-served
- Embraces principles of the system of care

The Integrated Policy and Plan to Provide and Improve Access to MH/MR/SA Services for Children, Adolescents, and their Families identified the following characteristics of an integrated system of mental health, mental retardation and substance abuse services:

- Easy access with free or sliding scale fees
- Centralized access to intake assessment
- Casemanagers operating across systems and providing families with guidance through the system.
- Central governance for policy, procedures, direction and information collection with evidence based practices
- Focus on early intervention and prevention
- Focus on non-crisis oriented treatment services
- Child and family involvement at all levels
- Culturally competent care

Section III.
Performance Goals and Action Plans to Improve the Service System

A. Plan for Adult Services

1. Current Activities

Criterion 1: Comprehensive community based services

In December 2002, Governor Warner proposed a multi-year vision to restructure Virginia's mental health services system. The goal of this restructuring process is to achieve a more comprehensive and fully developed system of community-based care. This would also serve to reduce the Commonwealth's reliance on state facilities for services that could be more appropriately provided in the community. Progress to date has included State Hospital diversion projects, plans for increased jail-based services, expansion of the types of mental health services available in the community and an increased focus on improving availability of geriatric mental health care. In one region, a new Crisis Stabilization Unit has served 81 individuals who were at risk of more restrictive levels of care. In another region, 35 individuals were discharged from a state hospital to more appropriate community placements.

In addition, DMHMRSAS has recently revised its mission to be:

> "We [DMHMRSAS Central Office] provide leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders. We seek to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals."

There is also a new vision of "a community-based system of services that promotes self-determination, empowerment, recovery, and the highest possible level of consumer participation in work, relationships, and all aspects of community life." The foundation of this vision includes: 1. Self-determination, empowerment and recovery, 2. Expanded quality of services including EBPs, 3. Access to care regardless of ability to pay, 4. Accountability through stakeholder monitoring of performance measures, 5. Partnerships with other local and state agencies, 6. Coordination of care, 7. Appropriate funding to address consumer needs, and 8. Efficient use of resources.

Performance Measures for Criterion 1

Five measures have been chosen for Criterion 1:

- Readmission Rate
- Number of evidence-based practice services
- Persons receiving evidence-based practice services
- Positive perceptions of outcomes
- Bed Day Rate

Criterion 2: Mental health system epidemiology

The quantitative target for 2003 focuses on maintaining or increasing the rate of treated prevalence of serious mental illness. It is encouraging that larger numbers of adults with serious mental illness have been served in recent years and a larger percentage all consumers treated are adults with serious mental illness; however a much higher penetration of the prevalence rate is desirable.

It is important to note that both the State Board policy on priority populations and the checklist criteria are considerably narrower than the criteria in the federal definition. This will cause the CSB penetration rates to be lower than they would be if the federal definition were applied, since the prevalence rates are based on the federal definition. While part of the discrepancy between prevalence and treated prevalence may be accounted for by the broader nature of the federal definition of serious mental illness relative to the State Board's, increasing CSB penetration rates continues to be an important goal of this plan. This measure has been a particular focal point for the Mental Health Planning Council and considerable emphasis will be placed on monitoring this data over the next few years.

Two measures have been chosen for Criterion 2:

- Number of persons served by the state mental health authority
- Treated prevalence of serious mental illness

Criterion 3: Not applicable to adult services

Criterion 4: Targeted services to rural and homeless populations

The Department, in partnership with the Virginia Department of Health (VDH), VPCA, and the Virginia Rural Health Resource Center (VRHRC) sponsored a two-day conference in September 2002 focusing on the integration of behavioral health into primary care.

In addition, DMHMRSAS has incorporated a number of steps to address the need for increased services in rural areas into its Comprehensive State Plan for 2004-2010 including convening a workgroup of state facility and CSB leaders to identify current and projected areas of service need.

a. Assess the capacity of current medical and clinical staff to meet the specialized service needs of individuals served by CSBs in rural and clinically underserved areas.
b. Identify the availability of specialized medical and clinical expertise in state facility programs by state facility service area.
c. Develop strategies to provide state facility specialized medical and clinical staff for treatment and consultation services to CSBs that have current and projected shortages.
d. Use state facility medical and clinical specialists to provide training to CSB personnel in identified areas of need, using interactive telecommunication networks and video technology.
e. Advocate Federal regulatory revisions to assess per capita allotments fairly within state allocations in distributing transportation funding so that amounts would be allotted equitably among rural and urban populations.

Virginia is committed to providing services to individuals with serious mental illness who are homeless. It has been estimated that between 12 and 20,000 individuals with mental illness become homeless. Virginia is a recipient of Projects for Assistance in Transition from Homelessness (PATH) formula grant. This grant provides funds for outreach to persons who are homeless and have serious mental illness across the state.

The performance measure chosen for Criterion 4 is level of shelter, housing and mental health services to homeless adults with serious mental illness.

Criterion 5: Management Systems

DMHMRSAS is the primary funding source for public mental health services in Virginia. Other revenues include Medicaid, other third-party payments, Federal grant funds and local tax revenues. The community mental health system is underfunded to provide all needed community-based services. This fact underlines the significance of the Community Mental Health Services Block Grant funds as part of the total resources used for community services.

In Virginia, a community mental health center (CMHC) is defined as a local entity through which comprehensive community mental health services are provided. These services are provided within the framework of the Commonwealth's core services, and within the structure of the Code of Virginia (37.1-194-202.1) establishing the community services boards (CSBs). Mental Health block grant funds are allocated to Virginia's community services boards and to consumer-operated, community-based programs.

Mental Health Block Grant funds are primarily used in Virginia to support and develop services through CSBs. These services are restricted to non-residential and outpatient services and supports in accordance with P.L. 102-321. CSBs use the Block Grant funds, in conjunction with other state and local funds, to maintain and expand the array of community-based services for adults with serious mental illness.

The performance measure chosen for Criterion 5 is the percentage of SMHA-controlled expenditures used to support community programs.

Adult Criterion 1: Readmission Rate

Goal: Decrease rate of readmissions to State Psychiatric Hospitals within 30 days.

Target: To decrease the rate of readmissions to State Psychiatric Hospitals within 30 days to 8.9%

Population: Non-Forensic Adults with Serious Mental Illness

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Brief Name: Readmission Rate

Indicator 1: Reduced Utilization of Psychiatric Inpatient Beds

Measure: The rate of readmissions within 30 days of discharge from the state mental health facilities for non-forensic consumers for whom the CSB is the case management CSB.

> Numerator: Number of non-forensic patients readmitted to state mental health facilities within 30 days of discharge during the fiscal year.
>
> Denominator: Number of discharges of non-forensic patients from state mental health facilities within the fiscal year.

Source(s) of Information: Hospital Information System (AVATAR)

Significance: Reduction in the rate of readmissions is a measure of the capacity of community services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	8.3%	8.9%	8.9%	8.7%	8.5%
Numerator	336	---			
Denominator	4,058	---			

Action Plans: The Department has implemented a number of measures to decrease the states reliance on inpatient hospitalization and has plans to expand these services.

1. *Discharge Assistance Plans* (DAP) are designed to assist in the preparation of individuals returning to the community after inpatient care.

2. *Crisis Stabilization Units* are being developed to serve individuals at risk of more restrictive levels of care. One region has already served 81 individuals.

3. *Programs of Assertive Treatment* (PACT) teams provide intensive treatment, rehabilitation, and support services that reduce state hospital utilization. There are currently 13 PACT teams with plans for 3 more.

4. *Projects for Assistance in Transition from Homelessness* (PATH) program funds outreach and engagement services to persons who are homeless and have serious mental illness across the state. A recent study (Culhane et al, 2002) on the impact of supportive housing programs for persons who were homeless and had serious mental illness revealed that those placed in supportive housing programs experience marked reductions in shelter use, hospitalizations, length of stay when re-hospitalized, and incarceration.

5. *Gero-psychiatric Work Group* has been established by DMHMRSAS to create a strategic plan for the development of needed services and support for elderly individuals and adults with serious mental illnesses. Currently, these individuals remain in state hospitals even after they are stabilized because they require a level of services that is beyond the capacity of nursing homes to provide. The Work Group is reviewing the system of public gero-psychiatric care in order to assess the sufficiency, comprehensiveness, and coordination of services. The Work Group also is evaluating a variety of potential treatment models for statewide development. During FY 2004, the Gero-Psychiatric Work Group will focus primarily on gathering and reviewing data that will identify service needs for this population. A secondary initiative during FY 2004 will be the development of an educational program for direct caregivers.

6. *Readmission Rate* has also been chosen as a measure to report to the Department of Planning and Budget. This means that performance on this measure will be available for key stakeholders to review.

7. *WRAP* (Wellness Recovery Action Plans) programs have also been funded by the Department. According to the author (Mary Ellen Copeland), “The Wellness Recovery Action Plan is a structured system for monitoring uncomfortable and distressing symptoms, and, through planned responses, reducing, modifying or eliminating those symptoms.”

Adult Criterion 1: Number of Evidence-Based Practices

Goal: To track the number of evidence-based practice services provided by the state mental health authority (SMHA).

Target: Establish a baseline for the number of evidence-based practice services provided by the SMHA.

Population: Adults with Serious Mental Illness

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Brief Name: Number of Evidence-based Practices

Indicator 2: Evidence-based practice services provided by the SMHA

Measure: Number of evidence-based practice services provided by the SMHA (out of 8 possible)

Source of Information: Survey

Significance: Evidence-based practices (EBPs) represent practices that have research supporting their efficacy. Use of EBPs should result in better patient outcomes.

Special Issues: Data for this measure was collected from a self-report survey. While we provided CMHS definitions of the EBPs to survey respondents, we do not currently check fidelity.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	N/A	TBD	TBD	TBD
Numerator		---			
Denominator	---	---	---	---	---

Action Plans: Currently, Virginia does not collect any data on EBPs. In 2004, we plan to survey CSBs regarding their use of the eight EBPs identified by CMHS. Currently, we have 13 PACT teams that meet the EBP criteria and there are plans for three more. Goals for 2005, 2006 and 2007 will be set according to the baseline established from the 2004 survey.

Adult Criterion 1: Number of Adults Receiving Evidence-Based Practice Services

Goal: To track the number of adults who receive evidence-based practice services (EBPs).

Target: Establish a baseline for the number of people who receive EBPs

Population: Adults with serious mental illness

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Brief Name: Number of adults receiving EBPs

Indicator 3: Evidence-based Practice Services

Measure: Number of adults receiving EBPs

Source(s) of Information: Survey of CSBs

Significance: Evidence-based practices represent practices that have research supporting their efficacy. Use of EBPs should result in better patient outcomes.

Special Issues: Data for this measure was collected from a self-report survey. While we provided CMHS definitions of the EBPs to survey respondents, we do not currently check fidelity.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	N/A	TBD	TBD	TBD
Numerator		---			
Denominator	---	---	---	---	---

Action Plans: Currently, Virginia does not collect any data on EBPs. In 2004, we plan to survey CSBs regarding their use of the 8 EBPs identified by CMHS. Currently, we have 13 PACT teams that meet the EBP criteria and there are plans for three more. We can track the number of adults receiving PACT services and have plans to include other EBP services in our state MIS system to allow us to better track the number of individuals who receive such services. In the meantime, we plan to use a survey requesting that CSBs tell us which EBPs they are implementing and how many people they serve. Goals for 2005, 2006 and 2007 will be set based on the baseline established from the 2004 survey.

Adult Criterion 1: Positive Perceptions of Outcomes

Goal: To maintain or increase the percent of persons who report positive perceptions of outcomes on the MHSIP Adult Consumer Survey

Target: To maintain the percent of persons who report positive perceptions of outcomes on the MHSIP Adult Consumer Survey at 69%.

Population: Adults with serious mental illness

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Brief Name: Positive Perceptions of Outcomes

Indicator 4: Client Perception of Care

Measure: Percent of clients reporting positively about outcomes (Number of Clients Reporting Positively About Outcomes) on the MHSIP Adult Consumer Survey.

Numerator: Number of positive responses reported in the outcome domain on the MHSIP Adult Consumer Survey.

Denominator: Total number of respondents to the outcome domain on the MHSIP Adult Consumer Survey.

Source(s) of Information: MHSIP Adult Consumer Survey

Significance: It is important to know what consumers think about the effectiveness of service delivery.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	69.2%	69%	69%	69.1%	69.1%
Numerator	3,083	---	---	---	---
Denominator	4,341	---	---	---	---

Action Plans: The Department has several committees that look at outcome performance measures. In addition, the Department has provided funding for the creation of a statewide consumer network. We continue to be committed to providing quality services in the community. As our community services expand, consumer outcomes should improve.

Adult Criterion 1: Bed Day Utilization

Goal: To reduce the utilization of state mental health facilities

Target: To reduce the number of patient bed days of service provided in state mental health facilities per 100,000 population 18 years of age or older to 10.5

Population: Adults Diagnosed with a Serious Mental Illness

Criterion 1: Comprehensive Community-based Mental Health Service Systems

Brief Name: Bed Day Rate

Indicator 5: Number of patient bed days of service provided in state mental health facilities per 100,000 population 18 years of age or older.

Measure:

Numerator: Number of patient bed days provided in state mental health facilities.
Denominator: 2000 Census data on population 18 years of age or older.

Sources of Information:

Numerator: Community Consumer Submission
Denominator: Weldon Cooper Center for Public Service, University of Virginia

Significance: Decreased lengths of stay in state mental health facilities should accompany improvement in the community-based service system for adults with serious mental illness. Shorter lengths of stay and discharge to the community with appropriate supports are the desirable outcomes.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	10.6	10.5	10.5	10	9.5
Numerator	564.7k	---	---	---	---
Denominator	5.3M	---	---	---	---

Action Plans: The Department has implemented a number of measures to decrease the states reliance on inpatient hospitalization and has plans to expand these services. See the Action Plan under readmission rate for a more complete description of the services below.

1. *Discharge Assistance Plans* (DAP)
2. *Crisis Stabilization Units*
3. *Programs of Assertive Treatment* (PACT) teams
4. *Projects for Assistance in Transition from Homelessness* (PATH)
5. *Gero-psychiatric Work Group*
6. *WRAP* (Wellness Recovery Action Plans) programs

Adult Criterion 2: Adults Served by the SMHA.

Goal: To maintain or increase the number of adults who receive mental health services from the state mental health authority (SMHA).

Target: To maintain the number of persons who receive mental health services from the SMHA at 92,000

Population: Adults

Criterion 2: Mental Health System Data Epidemiology

Brief Name: Adults served by the SMHA

Indicator 1: Increased Access to Services

Measure: Count of adults who receive mental health services from either a CSB or a state mental health hospital during the fiscal year.

Source(s) of Information: Community Consumer Submission; Hospital Information Systems (AVATAR).

Significance: It is important to provide treatment to as many individuals with mental illness as possible.

Special Issues: This indicator does not include data about persons receiving services through private providers.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	92,242	92,000	92,000	93,000	94,000
Numerator	92,242	92,000	92,000	93,000	94,000
Denominator	---	---	---	---	---

Action Plans: Virginia has a history of successfully meeting previous goals for this indicator and DMHMRSAS was successful in getting additional funds for FY 2004 from the General Assembly to expand the array of services.

Adult Criterion 2: Treated Prevalence of Mental Illness

Goal: To maintain or expand access to mental health services for the population of persons who have a serious mental illness.

Target: To maintain the treated prevalence of serious mental illness at 14.5%.

Population: Adults with Serious Mental Illness

Criterion 2: Mental Health System Data Epidemiology

Brief Name: Treated Prevalence of Serious Mental Illness

Indicator 2: The percentage of adults with a serious mental illness who receive public mental health services from community services boards during the fiscal year.

Measure:

Numerator: Number of adults who have a serious mental illness (as defined by the priority populations) and who have received mental health services from community services boards during the fiscal year.

Denominator: Federal estimates of the number of adults who annually have a serious mental illness in the State.

Sources of Information:

Numerator: Community Consumer Submission

Denominator: State estimates of prevalence by Kessler, et al. (1997) published in the Federal Register.

Special Issues: This indicator does not include data on individuals receiving services through private providers.

Significance: Setting quantitative targets to be achieved for the numbers of adults with serious mentally illness to be served by the public mental health system is a key requirement of the mental health block grant law. Penetration of the population affected by serious mental illness is a critical building block of the community-based care system.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	15.7%	14.5%	14.5%	14.75%	15%
Numerator	45,035	---	---	---	---
Denominator	286,988	---	---	---	---

Action Plans: Virginia has a history of successfully meeting previous goals for this indicator and DMHMRSAS was successful in getting additional funds for FY 2004 from the General Assembly to expand the array of services.

Criterion 3: Applies only to children's services.

Adult Criterion 4: PATH Performance and Outcome Measurements

Goal: To maintain the level of shelter, housing and mental health services to homeless adults with serious mental illness.

Target: To maintain the level of shelter, housing and mental health services to homeless adults with serious mental illness at 85%

Population: Adults with Serious Mental Illness

Criterion 4: Targeted Services to Homeless and Rural Populations

Brief Name: PATH Performance and Outcome Measurements

Indicator 1: Composite score for PATH mental health services, shelter & housing assistance.

Measure:

Numerator: Composite Score, MH and Housing Services
Denominator: Estimate of 13,123 homeless persons with serious mental illness

Sources of Information:

Numerator: PATH Mental Health Services + Shelter and Housing Services

1. PATH Mental Health Services
   Outreach contacts and referrals
   Clients referred to mental health services
   Clients placed in mental health services

2. PATH Shelter and Housing Services
   Clients placed in shelter
   Clients referred to housing
   Clients assisted with housing applications
   Clients placed in housing

Denominator: Average of the following two estimates applied to prevalence estimate of SMI in Virginia

1. 5% of people with SMI are homeless (Federal Task Force on Homelessness and Mental Illness, 1992).
2. 8.4% of Medicaid recipients with record of treatment for serious mental illness were served in homeless shelters in Philadelphia over a three year period (Culhane et al. 1997)

Significance: Accessing and maintaining these services is critical to homeless adults with serious mental illness.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	90.8%	85%	85%	87%	89%
Numerator	11,916	---	---	---	---
Denominator	13,123	---	---	---	---

Action Plans: As of SFY 04, there are eighteen PATH sites in the Commonwealth of Virginia. The total SFY 2004 federal award for Virginia is $897,000. There are plans to add three new sites in partnership with a state housing authority and an increase in the level of training provided to sites regarding providing mainstream services to homeless individuals with SMI.

Adult Criterion 5: Support for Community Programs

Goal: To maintain or increase the percentage of SMHA-controlled expenditures used to support community programs.

Target: To maintain the percentage of SMHA-controlled expenditures used to support community programs at 28%.

Population: Adults with Serious Mental Illness

Criterion 5: Management systems

Brief Name: Support for Community Programs

Indicator 1: Percent of SMHA-controlled resources distributed CSBs

Measure:

Numerator: SMHA-controlled resources distributed to community services boards for adult services.

Denominator: Total SMHA-controlled resources (Central Office, State Facilities, CSBs - includes state general funds, federal block grant, Medicaid, and Medicare)

Sources of Information: State financial management system

Significance: Adequate funding is essential to building the community-based system of care. Measuring the proportion of SMHA-controlled resources supporting community programs is one indicator of progress.

Special Issues: The amount of money for adult services is calculated by taking the total expenditures for each core service category, multiplying it by the proportion of clients served in that core service who are 18 or older, and summing this figure across all core service categories.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY 2004 Projected	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	30.6%	28%	28%	29%	30%
Numerator	141.6M	---	---	---	---
Denominator	462.8M	---	---	---	---

Action Plans: The Commonwealth continues to support the restructuring process, one part of which serves to divert funds from inpatient state hospitals to community programs. In addition, the largest share of the Mental Health Block Grant goes to Community Services Boards. We also actively encourage CSBs to maximize their Medicaid reimbursements.

B. Plan for Children's Services

2. Current Activities

Criterion 1: Comprehensive community based services

The establishment and implementation of a community-based system of care for children and their families is the essential goal of the statewide mental health plan. Such a system would offer a wide array of community services and minimize reliance on costly and restrictive inpatient and residential services.

Based on a review of inpatient hospital data, Virginia is serving more children for shorter lengths of time on an inpatient basis. Virginia has been experiencing extraordinary budget reductions which affect the capacity of localities to fund appropriate community placements for children. While it is the intention of the state to eliminate unnecessary reliance on inpatient care, critical care needs and safety of children with serious emotional disturbance cannot be overlooked when hospitalization appears to be necessary.

Therapeutic foster care has been recognized as an evidence-based practice for children that can help avoid hospitalization for some children. Virginia has been providing therapeutic foster care in collaboration with local departments of social services for at least a decade. However, considerably more therapeutic foster families are required to meet the need. Additionally, mechanisms for monitoring fidelity to the therapeutic foster care treatment model must be developed. Other evidence-based practices, such as multi-systemic therapy (MST) and functional family therapy, are provided in some parts of the state. Currently, DMHRSAS is surveying all CSBs to gather data on evidence-based practices that they provide and their methods for measuring fidelity to each evidence-based practice service model.

Performance Measures for Criterion 1

Three measures are provided for Criterion 1. They are:

- Readmission Rate
- Number of children receiving therapeutic foster care
- Bed Day Rate

Criterion 2: Mental health system epidemiology

The quantitative target for criterion 2 focuses on increasing the rate of treated prevalence of serious emotional disturbance in youth under the age of eighteen. It is important to note that the current DMHMRSAS definition of serious emotional disturbance is more exclusive than the federal definition. This is significant because it will cause the CSB penetration rates to be lower than they would be if the federal definition were applied. However, given that this definition is consistently used from year to year, the goal of increasing the numbers of children with serious emotional disturbance served remains valid.

In FY 2003, the Commonwealth of Virginia successfully achieved the stated goal of increasing the total number of children treated for serious emotional disturbance. Over the past four years, Virginia has consistently increased the number of children with serious emotional disturbance served across the Commonwealth. While we hope to continue to increase the number of children served, the Commonwealth is experiencing extremely difficult budgetary shortages.

Two measures have been chosen for Criterion 2:

- Number of children served by the SMHA
- Treated Prevalence of serious emotional disturbance

Criterion 3: Children's services

The 2000-2002 Appropriation Act included language (Item 329-G) directing the Department and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, CSBs, and court service units, to develop an integrated policy and plan, to provide and improve access by children to mental health and mental retardation services. The Department established a workgroup representing CSBs, state agencies, parents, and other partners to identify service needs and develop the *Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation and Substance Services for Children, Adolescents and Their Families*, hereafter referred as the 329-G Report. The Child and Adolescent Special Population Work Group includes representatives from parent organizations, CSBs, state and private hospitals serving children, and state agencies. Work Group recommendations for 2004-2006 biennium budget funding include:

1. Statewide CSB cross-consultation and training ($200,000 jointly managed by the Department and VACSB.
2. Dedicated funding for child and adolescent MH, MR, SA, and early intervention services. ($40 million divided across the CSBs).
3. Medicaid rate increase for MH Clinics, EPSDT (day and intensive in-home) and psychiatric acute inpatient services (10 percent annually) and increase the diagnoses covered to include all Axis I diagnoses (except nicotine dependence.
4. Child board-eligible or certified psychiatrists at each CSB ($8 million)
5. Stipends for child psychiatry fellows and doctoral interns in clinical psychology to build Virginia capacity ($290,000).
6. Grant support for matching funds for five consecutive years ($1 million).

Work Group recommendations not linked to funding include:

1. Develop and promote a vision and roadmap for the integration of child and family services statewide and do strategic planning.
2. Disseminate the Commission on Youth's "Collection" of evidence-based practices.
3. Seek grant funding options (through private foundations) to build matching funds capacity.

4. Support the development of a statewide bed tracking system.
5. Dialogue with state universities on capacity building, especially child psychiatrists and psychologists.
6. Review and revise the Department's discharge protocols for children and adolescents.

The Work Group will continue to develop plans related to community-based best practices, integration of services and addressing the needs of special population, and residential and detention services. The Department has also created a statewide department to oversee all children's services.

In the provision of children's mental health services, the Commonwealth of Virginia recognizes the growing need to ensure that services are delivered in a manner that respects the uniqueness of all ethnic/cultural groups represented in Virginia. Over the past several years, the DMHMRSAS has encouraged local providers of children's mental health services to implement policies and procedures that support cultural competence that is tailored to the communities they serve. Effective cultural competency in mental health service provision should integrate an awareness of individuals and groups of people into specific standards, service approaches and treatment strategies. Virginia measures cultural competency from the Youth Services Survey for Families YSS-F.

Two measures have been chosen for Criterion 3:

- Positive perceptions of outcomes
- Cultural competency self-assessment

Criterion 4: Targeted services to rural and homeless populations

The Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services designates areas as rural based on a population of less than 120 per square mile. Currently the Commonwealth of Virginia has 40 CBSs of which 17 are designated as urban and 23 are designated as rural. The 40 CSBs provide services to residents of all 135 counties in Virginia. The availability of services for children with serious emotional disturbance residing in rural catchment areas has been selected as a performance measure for Criterion 4.

Criterion 5: Management Systems

DMHMRSAS is the primary funding source for public mental health services in Virginia. Other revenues include Medicaid, other third-party payments, Federal grant funds and local tax revenues. The community mental health system is underfunded to provide all needed community-based services. This fact underlines the significance of the Community Mental Health Services Block Grant funds as part of the total resources used for community services.

In Virginia, a community mental health center (CMHC) is defined as a local entity through which comprehensive community mental health services are provided. These services are provided within the framework of the Commonwealth's core services, and within the structure of the Code of Virginia (37.1-194-202.1) establishing the community services boards (CSBs). Mental Health block grant funds are allocated to Virginia's community services boards and to

consumer-operated, community-based programs. CSBs use the Block Grant funds, in conjunction with other state and local funds, to maintain and expand the array of community-based services for adults with serious mental illness.

The performance measure chosen for Criterion 5 is the percentage of SMHA-controlled expenditures used to support community programs for children and adolescents.

2. Goals, Targets and Action Plans

Criterion 1: Comprehensive Community-Based Mental Health Service Systems.

Child Criterion 1: Readmission Rate

Goal: To maintain the rate of readmissions to State Psychiatric Hospitals within 30 days.

Target: To maintain the rate of readmission to State Psychiatric Hospitals within 30 days at 6.3%

Population: Persons under the age of 18.

Criterion 1: Comprehensive community-based mental health service systems

Brief Name: Readmission Rate

Indicator1: Reduced Utilization of Psychiatric Inpatient Beds

Measure: The rate of readmissions within 30 days of discharge from the state mental health facilities for children and adolescents for whom the CSB is the case management CSB.

Numerator: Number of children and adolescents readmitted to state mental health facilities within 30 days of discharge during the fiscal year.
Denominator: Number of child and adolescent discharges from state mental health facilities within the fiscal year.

Source(s) of Information: Hospital Information System (AVATAR)

Significance: Reduction in the rate of readmissions is a measure of the capacity of community services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	6.3%	6.3%	6.3%	6.3%	6.3%
Numerator	36	---	---	---	---
Denominator	572	---	---	---	---

Action Plans: The Child and Adolescent Special Population Work Group recommended review and revision the Department's discharge protocols for children and adolescents. This in-depth analysis should result in better coordination of care in the community which should lower readmission rates.

Child Criterion 1: Number of Children Receiving Therapeutic Foster Care

Goal: To track the number of children and adolescents who receive therapeutic foster care.

Target: Establish a baseline for the number of children and adolescents who receive therapeutic foster care.

Population: Children and Adolescents with Serious Emotional Disturbance

Criterion 1: Comprehensive community-based mental health service systems

Brief Name: Therapeutic foster care

Indicator 2: Number of children and adolescents receiving therapeutic foster care

Measure: Count of the number of persons receiving evidence-based practice services.

Source of Information: Survey.

Significance: Evidence-based practices represent practices that have research supporting their efficacy. Use of EBPs should result in better patient outcomes.

Special Issues: Data for this measure was collected from a self-report survey. While we provided CMHS definitions of the evidence-based practices to survey respondents, we do not currently check fidelity.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	N/A	N/A	TBD	TBD	TBD
Numerator	---	---	---	---	---
Denominator	---	---	---	---	---

Action Plans: Currently, Virginia does not currently have any data on therapeutic foster care. We have plans to include this service in our state MIS system to allow us to better track the number of individuals who receive such services. In the meantime, we are surveying the CSBs to determine how many children and adolescents receive this service. Targets will be set according to baseline numbers.

Child Criterion 1: Bed Day Utilization

Goal: To maintain the utilization of state mental health facility beds for children.

Target: To maintain the number of patient bed days of service provided in state mental health facilities per 100,000 population 17 years of age or younger to .95

Population: Children and adolescents diagnosed with serious emotional disturbance

Criterion 1: Comprehensive Community-based Mental Health Service Systems

Brief Name: Bed Day Utilization Rate

Indicator 3: Number of patient bed days of service provided in state mental health facilities per 100,000 population 17 years of age or younger.

Measure:

Numerator: Number of patient bed days of service provided in state mental health facilities during the fiscal year to children and adolescents.

Denominator: 2000 Census data on population under 18 years of age.

Sources of Information:

Numerator: Hospital Information Systems (AVATAR)
Denominator: 2000 Census data, Weldon Cooper Center for Public Service, University of Virginia.

Significance: An increase in resources for community-based services for children and adolescents with serious emotional disturbance may help to maintain the current level of utilization of inpatient services in state mental health facilities. However, utilization may be at the lowest realistic rate now. There are only 64 state facility beds for children and adolescents.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	.90	.95	.95	.945	.94
Numerator	15.3k	---	---	---	---
Denominator	1.7M	---	---	---	---

Action Plans: The Department and the CSBs are working in partnership to expand community-based services, especially services to children who are not mandated under the Comprehensive Services Act funding. The 2004 General Assembly appropriated $2 million for this purpose.

Child Criterion 2: Treated Prevalence

Goal: To maintain or expand access to mental health services for children with serious emotional disturbance (SED)

Target: To maintain treated prevalence of serious emotional disturbance at or above 17%

Population: Children with serious emotional disturbance

Criterion 2: Mental Health system Data Epidemiology

Brief Name: Treated prevalence of serious emotional disturbance

Indicator 1: The percentage of children with SED who receive mental health services from CSBs during the fiscal year.

Measure:

Numerator: Number of children with SED who received mental health services.
Denominator: Number of children with SED in the State.

Sources of Information:

Numerator: Community Consumer Submission
Denominator: Federal estimate of prevalence of serious emotional disturbance

Significance: Setting quantitative goals for the numbers of children with serious emotional disturbance to be served in the public mental health system is a requirement of the mental health block grant law. Penetration of the population affected by serious emotional disturbance is a critical building block of community-based systems of care.

Special Issues: It is important to note that this data includes only those children with SED served by CSBs. The reported number of children served may decline due to the use of managed care services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	19.3%	17%	17%	18%	19%
Numerator	14,995	---	---	---	---
Denominator	77,726	---	---	---	---

Action Plans: Community Services Boards work with local school systems and social services to identify children in need of services. In addition, there is ongoing outreach to refer parents to Virginia's health insurance program for children (FAMIS). FAMIS provides access to quality health services for children of working families. There is no enrollment or monthly premium fees for FAMIS and the co-pays are nominal.

Child Criterion 2: Number of children served.

Goal: To increase the number of persons under the age of 18 served.

Target: To increase the number of persons under the age of 18 served to 22,000.

Population: Persons under the age of 18.

Criterion 2: Mental Health system Data Epidemiology

Brief Name: Children and Adolescents Served

Indicator 2: Increased access to services.

Measure: Count of the number of persons under the age of 18 who are served by the state mental health authority.

Sources of Information: Community Consumer Submission; Hospital Information System.

Significance: It is important to provide treatment to as many individuals with mental illness as possible.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	21,941	22,000	22,000	22,200	22,400
Numerator	21,941	---	---	---	---
Denominator	---	---	---	---	---

Action Plans: Community Services Boards work with local school systems and social services to identify children in need of services. In addition, there is ongoing outreach to refer parents to Virginia's health insurance program for children (FAMIS). FAMIS provides access to quality health services for children of working families. There is no enrollment or monthly premium fees for FAMIS and the co-pays are nominal.

Child Criterion 3: Positive Perceptions of Outcomes.

Goal: To maintain or increase the percent of caregivers reporting positively about their child's outcomes.

Target: To maintain the percent of caregivers reporting positively about their child's outcomes at 47%.

Population: Persons under the age of 18.

Criterion 3: Children's Services

Brief Name: Positive perceptions of outcomes.

Indicator 1: Perception of Care

Measure: The percent of caregivers reporting positively about their child's outcomes on the Youth Services Survey for Families (YSS-F).

Numerator: Number of positive responses in the outcome domain on the YSS-F

Denominator: Total number of respondents to the outcome domain on the YSS-F

Sources of Information: Youth Services Survey for Families

Significance: It is important to know what consumers think about the effectiveness of service delivery.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	51.4%	47%	47%	47.5%	48%
Numerator	430	---	---	---	---
Denominator	837	---	---	---	---

Action Plans: The Department has several committees that look at outcome performance measures. In addition, the Department has provided funding for the creation of a statewide consumer network. We continue to be committed to providing quality services in the community. As our community services expand, consumer outcomes should improve.

Child Criterion 3: Cultural Competence.

Goal: Maintain cultural competency of Community Service Boards

Target: To maintain the percent of caregivers reporting positive perceptions of the CSB staff's sensitivity to cultural/ethnic background at 86%

Population: Children with serious emotional disturbance

Criterion 3: Provision of children's services

Brief Name: Cultural Competency Self-assessment

Indicator 2: Percentage of consumer's caregivers who report satisfaction with staff sensitivity to cultural/ethnic background.

Measure: Numerator: Total number of respondents with average scale score >3.5 on the cultural sensitivity subscale.

Denominator: Total number of respondents.

Sources of Information: Youth Services Survey for Families (YSS-F)

Significance: The cultural competency of a program increases the likelihood that members of minority groups will successfully engage in treatment.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	89.4%	86%	86%	86.3%	86.6%
Numerator	743	---	---	---	---
Denominator	831	---	---	---	---

Action Plans: Over the past several years, the DMHMRSAS has encouraged local providers of children's mental health services to implement policies and procedures that support cultural competence that is tailored to the communities they serve. The Department plans to distribute cultural competency scores on the YSS-F to all CSBs so that they are aware of the perception that caregivers of child consumers have of the cultural sensitivity of their staff. CSBs that have a low score on this scale will be offered TA to assist them in improving their score.

Child Criterion 4: Children served in rural CSBs.

Goal: To maintain or increase the availability of mental health services for children with serious emotional disturbance in rural areas.

Target: To maintain the number of children with SED served in rural community services boards at 7,600.

Population: Children with serious emotional disturbance

Criterion 4: Targeted Services to Homeless and Rural Populations

Brief Name: Rural mental health services

Indicator 1: Services to children with SED in rural areas

Measure: Number of children with SED served in rural community services boards

Sources of Information: Community Consumer Submission

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	7,959	7,600	7,600	7,700	7.800
Numerator	---	---	---	---	---
Denominator	---	---	---	---	---

Action Plans: Virginia has consistently increased the numbers of children served in rural CSBs in recent years.

Child Criterion 5: Support for child mental health programs in the community.

Goal: Increase percentage of funding expended for child and adolescent mental health services.

Target: To increase the percentage of funding expended for child and adolescent mental health services to 7.3%

Population: Children with serious emotional disturbance

Criterion 5: Management Systems

Brief Name: Support for Child Mental Health Programs

Indicator 1: Percentage of SMHA-controlled resources distributed to community services boards specifically for child mental health services.

Measure:

Numerator: SMHA-controlled resources distributed through grants to community services boards for child mental health services.

Denominator: Total SMHA-controlled resources (for Central Office, State Facilities, community services boards, including state general funds, federal block grant, Medicaid, Medicare)

Sources of Information: State financial management system

Significance: Increased funding for the child and adolescent component of the state mental health system will increase the ability of CSBs to develop foundation services for children.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	7.7%	7.3%	7.3%	7.4%	7.5%
Numerator	35.5M	---	---	---	---
Denominator	462.8M	---	---	---	---

Action Plans: Virginia will continue to seek increases in funding for CSB children's services through state funds, federal grants, Medicaid and other sources. Virginia will continue to assure that the largest share of the Mental Health Block Grant is used for CSB services. We will maintain or increase the amount of the Block Grant that is allocated for children's services. Currently, this amount ($2,393,943) exceeds the set-aside requirements of $1,501,623. CSBs also make every effort to maximize their Medicaid reimbursements.